THE MEDICAL AND SURGICAL REPORTER.

No. 1901. PHILADELPHIA, AUGUST 5, 1893. Vol. LXIX—No. 6

ORIGINAL ARTICLES.

THE USE OF MILK IN HEALTH.*

H. F. SLIFER, North Wales, Pa.

The object of this brief paper is to present a few important data upon which to base the rational administration of cow's milk in health.

Milk is a substance furnished and intended by nature as the sole food for the young of all mammals, and, for a considerable period of their existence, they feed upon it exclusively. It therefore, represents a complete food, in which are present all the elements necessary for the nutrition and growth of the body. The various substances composing milk, and their relative proportions vary within comparatively wide limits, not only in different races and breeds, but the milk of the individual is subject to extensive variation. Some of the causes are: age, period of lactation, nature and amount of food, time of feeding, state of health and the treatment of the animal,—scrupulous care and kindness should ever attend the milk-producing cow.

It is stated on good authority, that a cow, if frightened, will lose a large percentage of her butter fats for twenty-four hours. As showing the influence of the nervous system on the formation of milk, and controlling the relative proportions, also the total amount of solids: two years ago I attended a child in convulsions caused by the ingestion of unhealthy milk. On investigation, I ascertained that the milk had been secured from a cow that during the night had broken her chain and gained access to a barrel of swill, from which she gorged herself. A few days since, I saw a child suffering from indigestion, fever and vomiting produced by the taking of its mother's milk which, later in the day, it refused. In this case, the milk was altered through the influence of emotional excitement brought on by an altercation with her husband on the subject of intemperance.

It is evident that many conditions will influence the character of milk, varying in degree from a slight loss in the percentage of some of its constituents, to a profound chemical change so that it becomes poisonous.

In consulting the different authors, I find a marked discrepancy in the analysis of milk, showing conclusively that it is not uniform in its composition. According to Foster[1] milk contains:—

	Woman.	Cow.
Water	90.	87.
Fats	2.75	4.
Sugar	5.	4.4
Proteids	2.	4.
Salts	.25	.60
	100.00	100.00

The fact that human milk is poorer in proteids, fats and salts, is of practical importance when cow's milk is substituted in the feeding of infants. The chemical reaction of human milk is alkaline; cow's milk neutral or acid. Human milk is free from bacteria; cow's milk contains numerous bacteria, when it reaches the con-

*Read before the Montgomery County Medical Society July 26, 1893.

1 Text Book on Physiology.

sumer. Human milk is richer in sugar and water than cow's milk.

In the process of digestion, the casein of human milk coagulates in small flœculi in the stomach and is readily digested, while that of cow's milk forms large and firm coagula which dissolves with difficulty in the gastric juice. In prescribing milk, it behooves to keep constantly before the mind the above facts to assure success in the use of this important agent. I am of the opinion, that, with close study of each case on the part of the physician, and a reasonable amount of intelligence on the part of the mother or nurse, the cow's milk can be so modified as to bear so close a resemblance to human milk, that it becomes applicable in a large majority of cases.

Moreover, it has been conceded by all the higher authorities that animal milk is the proper food for children during the period of growth and development.

Prof. Henoch,[2] of Germany, says: "Cow's milk is but the substitute for mother's milk during the entire period of infancy. I consider the administration of other substances advisable only when good cow's milk cannot be obtained."

J. Lewis Smith,[3] of New York, says: "Milk should be the chief article of food during infancy, after the first year the food may be made of such consistence as to be given with the spoon."

A. Jacobi,[4] of New York, says: "The substitute should be as near normal woman's milk as possible; and naturally, when the latter cannot be had, animal milks are selected."

For the adult body in a state of health, milk is not a typical food. To furnish the required amount of carbo-hydrates, to supply potential energy for moderate labor, twenty pints would be required, which would give an excess of fats and proteids; so large a quantity of fluid would interfere with the digestive function, and soon overtax the kidneys.

The food for adults, therefore, must be more concentrated, and richer in the carbohydrates.

The most important use of milk in health, is in the feeding of infants and children. During this period, when the circulation and metabolism is most active, the tissues containing an excess of water, milk is peculiarly adapted for the nutrition of the body.

To be successful in the use of milk, the following condition must be observed:

1, The quality of milk used.
2, " quantity of milk used.
3, " time of feeding.
4, " manner of feeding.
5, " proper dilution.
6, " " addition.
7, " predigestion.

Milk should be as fresh as possible, and preserved upon ice. If this is impracticable, it should be sterilized and bottled and kept cool. If milk free from impurities and perfectly fresh can be procured twice daily, it is not always essential that it should be sterilized. Milk should have a sweetish taste. Neutral or but faintly acid in reaction. Sp. Gr. 1029. Should contain not less than 3 per cent., nor more than 4½ per cent of fats. The proteids, consisting of albunium and casein, should constitute about 4 per cent. The salts, consisting of phosphate of calcium, potassium and magnesium, potassium chloride with traces of iron and other substances, must also exist in a fair percentage. The fats and proteids are more subject to variations than other constituents of milk; therefore, demanding the most careful attention.

In regard to the quantity of milk given at each feeding, much care should be exercised. I am convinced that more children are over fed, than underfed. We should ever remember the capacity of the little stomachs, designed to receive and digest the milk.

According to the measurments of Dr. T. M. Rotch,[5] of Bostom, "The capacity of an infants stomach 5 days old is 25 cubic centimeters, (7½ drachms). Two months, 120 C. C (4 ounces). Twelve months, 300 C. C. (10 ounces). Two years, 740 C. C. (25 ounces). In regulating the amount of milk, a fixed rule cannot be adhered to in all cases, since individuals differ in their capacity and physiological demands. I am guided somewhat by the following index:

Age.	Intervals.	Amount.
1 Month	Every 2 hours during the day.	1 oz.
2 Months		2 "
3 "		3 "
4 "	Every 2½ hours during the day.	4 "
5 "		5 "
6 "		6 "
7 "	Every 3 hours during the day.	6 " to 8 "
8 "		
9 "		
10 "		
11 "		
12 "		

2 Lecture on Diseases of Children.
3 Diseases of Children.
4 Intestinal Diseases of Children.
5 Cyclopædia of Diseases of children, Keating.

I feed as little as possible between the hours of 9 P. M. and 5 A. M., thus to enable the child and attendant ample time for sleep. Some children can do with one feeding, others demand food two or three times during the night. As the child advances in age, I decrease the night feedings, and prolong the hours of sleep.

The manner of feeding resolves itself into the simplest possible mode. Infants under twelve months of age, should feed exclusively from the bottle. In selecting the fittings, avoid all ostentation; I prefer a plain bottle with a short neck, with the proper capacity adapted to the age of the child, a plain rubber nipple with a small aperture. The child while nursing should repose in a comfortable position, and attended by a person who will remove the bottle as soon as the supply of milk is exhausted. Under no conditions, should the child be permitted to suck or play with the empty bottle. It should immediately be cleaned and placed in water, or water with the addition of soda or borax, until the next feeding. Milk should always be given at a uniform temperature, approaching that of the normal temperature of the stomach, about 100° F.

In substituting cow's milk for human milk, it is important to modify the former, so as to more closely resemble the latter. In comparing the analyses of the two, we observe that the cow's milk is richer in proteids, fats and salts. Very naturally, we endeavor to reduce these elements to their proper percentage; this is accomplished by the addition of water, which reduces all the constituents in an equal proportion, even those that are already deficient; this necessitates the addition of such constituents. The water employed for dilution, should always be boiled to destroy all organic substances which it may contain.

Water not only acts as a diluent, but alters the physical condition of the casein so as to render it more digestable, by preventing the formation of large coagula during peptogenic digestion.

The degree of dilution neccessarily depends upon the composition of the milk, the age and condition of the child. The following is my rule for dilution:

Age		Part of Milk to		Parts of Water.
1 Month	1	"	2	"
2 months	1	"	2	"
3 "	2	"	2	"
6 "	3	"	2	"
9 "	3	"	1	"
12 "	6	"	1	"

In case of indigestion, which is frequently due to an inordinate amount of proteids or fats, my experience has taught me that by increased dilution, and a reduction in the quantity of each feeding, the child is soon restored to its normal condition. There are also cases in which the fats are poorly digested and cause fatty diarrhœa; under such conditions, a portion of the fats should be removed and the usual quantity of water added.

Milk that has been properly diluted requires the addition of such elements as are deficient. Sugar should be added to the amount of two drachms to the pint. The kind of sugar which should be used is unimportant. It is natural to suppose that milk-sugar should be prefered, since it is a normal constituent of milk. Cane sugar, however, is less liable to undergo fermentation and is more readily digested. If a good quality of milk is used, it is seldom necessary to add cream; yet, in cases of constipation I have found the addition of cream to be beneficial. Owing to cow's milk being more or less acid, the addition of an alkali is essential; bicarbonate of soda or lime water will meet this indication. If constipation exists, phosphate of soda or magnesia should be used. Authors frequently speak of additions of farinaceous substances. My experience with these agents has been unsatisfactory. They are useful only so far as their mechanical action on the milk and irritating influence on the bowels are desirable. They are objectionable for two reasons: 1st, they differ too materially from normal milk elements; 2nd, they are difficult to digest. During early childhood the peptogenic functions predominate; the diastatic functions are not fully developed until later in life; and not until these two functions are equally balanced do we find vegetable matter properly digested. These substances undergo a more radical chemical change during digestion than animal substances. Since the peristalis in children is more active and the bowel comparatively short—according to Treves: "the length of the small intestine at birth is nine feet, and the colon one foot,"—the food does not remain sufficient time in the bowels for perfect solution and absorption of vegetable substances.

In children of naturally feeble digestion it is necessary not only to modify the milk

by dilution and additions, but to predigest it to a degree that the most delicate stomach will retain and digest it. This is accomplished by the use of a digestion ferment, either pepsin or extract pancreatis. So far as my experience goes, I prefer the pancreatis, its peptoinizing action is more energetic and capable of digesting every form of food. The casein is so altered as to resemble human milk and is regarded by Dr. Albert R. Leeds as humanized milk.

In conclusion, as soon as the profession recognizes the importance of this subject, and exercise the same care in the selection and administration of milk that we exercise in the selection and administration of drugs; and more fully appreciate the appeal that is made to us year after year by that gigantic infant mortality, so soon will we reach a consummation most desirable.

CLINICAL LECTURES.

NASAL DEVIATIONS.

DR. GEORGE M. LEFFERTS.*

GENTLEMEN:—Nasal deviations may be divided into three great classes, viz: (1) Those due to severe crushing injuries, such as the kick of a horse, which belong to general surgery; (2) angular, curved, and sigmoid deviations; and (3) outgrowths from the nasal septum.

Setting aside the extreme cases of crushing injury of the nose, we come to a class of cases in which the injury may have occurred within the memory of the patient, but more frequently has happened so long ago that he does not recollect it at all. Rest assured, however, that somewhere in life-time of that patient if he have a nasal deviation, there has been an injury to the nasal septum. Probably when he was but a very little child, he has fallen, and the injury has been done at this time, and has not attracted any attention.

The septum should be a perfectly straight, thin, cartilaginous partition between the two nasal passages. The first form of injury to which I shall ask your attention is *angular deviation.*

On one side, you will notice a cartilaginous and bony projection, reaching well out into one nasal passage, and in the other nasal passage, there will be a concavity. The next form is known as *curved deviation.* In this, the bony septum is bowed out into a large curve, which is thin and quite resilent. Here, again, in the one passage there is a projection, and in the other, a corresponding concavity. The third or *sigmoid deviation,* is rather more difficult to diagnosticate. This diviation always involves both the cartilaginous and bony portions of the nasal septum.

These are the three forms which are commonly seen, and which are the only ones you need remember. In almost every case, these deviations have been produced by some injury at a remote period. All three forms give rise to nasal stenosis. The first result of a blow on the nose in childhood will be chronic hypertrophic rhinitis, a condition which requires years for its development. The deviated septum and the hypertrophic rhinitis together produce a severe stenosis, and as a result of this obstruction, the patient is deprived of the sense of smell, his voice is harsh and muffled, and his hearing is defective. This last condition is due to the fact that the chronic catarrhal process has extended through the Eustachian tubes, or, as a result of the constant rarification of the air in the middle ear, the external pressure constantly drives the drum inward, and this, with the chronic resulting hyperæmia, makes the patient more or less deaf. Secretions lodge upon the irregularities of the nasal passages; they are removed by the patient, and an abrasion or ulcer is the result; and is very commonly associated with recurrent epistaxis. In such cases, always look on the side of the nasal

*Professor of diseases of the throat and nose, College of Physicians and Surgeons, New York.

septum near the front, and you will often be rewarded by finding the origin of the bleeding. Let me repeat—as a result of the nasal deviation, there will be mouth-breathing, chronic pharyngitis, chronic laryngitis, occlusion of the nasal passages, loss of resonance of voice, epistaxis, and dry, inpacted secretions.

The sigmoid deviation is a comparatively rare form requiring special operative skill, and often a multiplicity of instruments for its proper relief; so, in order not to unduly complicate this subject, I shall exclude this from consideration, and shall ask your attention only to two common forms of nasal deviation—the angular and the curved.

With the Adams forceps, the nasal septum is grasped firmly, and twisted into place, and maintained in this new position by means of intra-nasal plugs during the healing process. It is a most uncomfortable treatment, and the results are most unsatisfactory. Another method of operating is with the stellate forceps, an instrument which makes a stellate incision through the curved deviation. This enables you to place the septum in the median line with much less force, and then the after-treatment is carried out with the intra-nasal plugs as before. The operation is theoretically very good, but the treatment is very annoying, and the results do not seem to me to justify its use.

Another operation consists in using a forceps which will punch out several pieces from the nasal septum in the portion of greatest convexity. You may undoubtedly by this means clear the nasal passages, but you have left a communication between the nasal passages, a condition which is almost certain to prove uncomfortable to the patient all his life time. A simpler, much more comfortable, and effective operation consists in introducing a long brass pin through the curve in such a way as to hold it approximately in the proper position. This process may be facilitated by making two or three slight incisions into the septum. This pin can be worn without great inconvenience to the patient until the septum no longer tends to return to its former abnormal position. This is the best method of treating curved deviation.

An angular deviation is best treated by sawing off or cutting off the obstruction under cocaine anæsthesia. In doing this, you must be careful not to make an opening into the adjoining nasal passage.

We must next consider out growths from the nasal septum—exostoses or enchondromata, if you please, There has been a blow on the nose which has most often driven the cartilaginous septum against the articulation of the vomer with the maxilla. This has resulted in a very slow perichondritis, and the slow formation of a cartilaginous or osseous tumor. The differential diagnosis is made from angular deviation by observing that there is no corresponding concavity in the other nasal passage. Hypertrophic nasal catarrh will occur in every case where there is a deviation or projection of the nasal septum. In this third class is to be found the most frequent causes of nasal occlusion, and also the simplest method of removing the obstruction. The operation is performed either with a nasal saw, or with the nasal trephine, driven by an electric motor.

A Taste for Science.

Little Dick—"I know how to tell how deep a well is without going down."

Father—"Ah, I'm glad to see my son has a taste for science. You drop in a stone and count the number of seconds required for the descent, I presume?"

Little Dick—"Oh, no, I tie the stone to a string and then measure the string."—*Good News.*

Otalgia.

Le Progres Medicale recommends the following in otalgia:

℞
Camphorated chloral..... 5 parts.
Glycerine.....30 "
Oil of sweet almonds.....10 "

Dip a tuft of cotton into this and introduce it into the patient's ear.

For Migrane.

The following is recommended:

℞
Butyl-chloral hydrat.....grs. xv.
Tinct. cannabis indicæ.....mxv.
Tinct. gelsemii.....mxxx.
Glycerin.....f℥iv.
Aquæ.....ad f℥iij.

Mix. Sig.—An ounce to be taken at once; to be repeated in half an hour.

If a Child Die in the Uterus, Prof. Parvin says, the mother will not manifest any unfavorable symptoms unless air enters the uterus, in which case putrefaction will take place with all its unfavorable symptoms, particularly diarrhœa and chills.

COMMUNICATIONS.

THE EARLY REMOVAL OF TUBERCULAR FOCI OF BONE.*

B. MERILL RICKETS, M. D., Cincinnati, Ohio.

It is not my intention to address you at any very great length, or present to you a subject upon which no thought has been given by the surgeons in general. My intention is to present some evidence that may lead us to make an earlier diagnosis and to adopt more prompt and radical measures in tuberculosis of the bones than are generally adopted. Tuberculosis is one of the greatest enemies which the human body encounters. It is surely the greatest destroyer of its bony anatomy. When once the frame, or any part thereof becomes diseased, the interest of all that is dependent upon it, becomes jeopardized. Syphilis has been accredited as the great destroyer of not only one, but of all kinds of tissue. It is a blessing compared to the ravages which tuberculosis produces, for in syphilis we have a remedy without much surgical interference. In tuberculosis, our hands seem to have been tied, and the wheel of progress in its treatment been made to stand still. There seems to be no constitutional treatment whatever of the least benefit in tubercular disease of the bones. It is not because there has been no effort, for medical literature has been flooded with the various remedies suggested for its cure. It seems now that tuberculin has fallen short of our expectations, failing in every particular, and giving no good results whatever. To my mind, the good to be obtained is through surgical interference only, and it then depends upon early operative procedures. Aseptic surgery has been the greatest boon to this class of work, and we must necessarily rely to a great degree upon cleanliness. However, we see how difficult it is to secure primary union even in the extirpation of tubercular glands. Seeing how hard it is to overcome these obstacles and to secure primary union in operation upon the soft tissue, we must necessarily shrug our shoulders when we come to the extirpation of tubercular disease of the bones and joints. However much I might be gratified to present this subject to you voluminously, I must confine myself to the early extirpation of the tubercular foci in the bones. I believe that surgeons in general are responsible for a large per cent. of the cripples as the result of tubercular disease, and I am thoroughly satisfied that there has been too much delay, and that we have expected nature to do what we ourselves should have done. My own plan has been to act promptly and radically where I have evipence of tubercular disease of either the shaft or epiphysis. Even where there is a question as to the identity, it is best to give the patient the benefit of a doubt and operate promptly. In nearly all of the cases where the periosteum is thickened and tender, we have reason to suspect the presence of tuberculosis. Even in cases of trauma, tubercular bacilli seem to find their way and develop rapidly in the injured tissue. When once they are implanted, they are not long in manifesting themselves and giving evidence of their presence; therefore, it is in just such cases as these, especially of the long bones, that an exploratory incision and early extirpation give such excellent results. It is a matter of course that one should hesitate to open a joint as promptly as he would a shaft, but unfortunately the shafts are not so frequently attacked as the epiphyses. It is a great question, and one which must be considered greatly from the light of experience, as to the time when a joint should be opened; however, I am safe in saying that the disease should be removed earlier when it attacks the epiphysis than when the shaft alone is involved. If the foci are thoroughly removed, let them be upon the surface or in the body of the epiphysis, then the destruction of bone is much less and its ability to repair itself much greater. Then too, when early extirpated, the possibility of the other bones being involved is lessened; the disease, when confined to *one foci*, is not so rapid in its progress as where several are to be found, although the single one

*Read Before Mitchell Dist. Med. Association, Baden Springs, Ind.

may be as large as several of the smaller ones combined. Then too, the greatest number of tubercular foci are found in the epiphysis because of its spongy nature. There is not so much liklihood of the foci being multiple in the shafts, because they are more compact.

I do not believe that there is one foci in a thousand that undergoes spontaneous recovery, let it be in the shaft or epiphysis; much less is it likely to recover when found in the epiphysis. Even rest, which has been so long considered a cure for tubercular joints, is of but little avail, giving to my mind, no evidence whatever of the reparative process as the result. When once an area has become attacked by the bacilli, there seems to be no limit to the destruction which it may produce. If they do not become multiple, the one will in the course of time destroy all the adjacent tissues. Tuberculosis of the epiphysis is what epithelioma is to the skin, and should be looked upon with as great consideration, and the treatment made as radical. The earlier an epithelioma is removed, the greater the chances for a permanent relief. Just so with a tuberculous area within the bone. The influence of the diseased area seems to be nothing more than that of a foreign body, except that the disease is more rapid and progressive. The opening of a joint free from any disease could result in nothing more than a certain amount of ankylosis. A joint affected with tuberculosis, necessarily results in ankylosis to a greater or less degree. Now, is it not better in cases where there is every indication of tubercular deposit, to give the patient the benefit of a doubt in exploratory incisions, followed, if necessary, by the removal of tuberculous matter? Until recently it was almost a crime to open the abdominal cavity. Now it has become quite a common occurrence, even though doubt exists as to what is to be found within that cavity. Just so with tuberculosis of shafts, and especially joints. What can we expect from any other than radical treatment? The development of large ovarian tumors does not now occur, simply because the gynecologists have become so skilled in making early diagnoses that procrastination can no longer be attributed to them. It is to be hoped that surgeons who are called upon to treat the various forms of tuberculosis, especially of joints, will not delay radical operative procedures until there is great derstruction of bone, accompanied by the formation of fistulæ. This is deplorable, and I think is largely due to the surgeon himself. Perhaps he does not early recognize the disease, or it may be due to his inclination to procrastinate, or his fear in assuming responsibility, but it is as unscientific to allow the head of the femur to become destroyed from tuberculosis, as it is to allow an ovarian tumor to grow until it weighs 50 or 75 pounds. It is one thing for the patient or other influences to be responsible for such a state of affairs, and it is another for the responsibility to rest upon the attending physician. Just how much of the adjacent bone should be removed with tubercular foci, is a question for the operator himself to decide. I have no doubt but that, in the majority of hip-joint cases, the disease has progressed to a greater degree than is generally supposed at the time it is presented for treatment. We must expect all degrees of progress in the destruction of bony tissue as long as the people are isolated and out of reach of surgical aid. Poverty and indifference are prominent factors in the delay of treating all classes of disease, but this should not be of any influence in establishing laws. Let the rules be established, and the good results made known, and there can be no plausible reason why the application should not become general.

A paste which will stick anything is said by Professor Winchell to be made as follows: Take two ounces of clear gum arabic, one and one-half ounces of fine starch, and half an ounce of white sugar. Dissolve the gum arabic in as much water as the laundress would use for the quantity of starch indicated. Mix the starch and sugar with the mucilage. Then cook the mixture in a vessel suspended in boiling water, until the starch becomes clear. The cement should be as thick as tar, and kept so. It can be kept from spoiling by the addition of camphor, or a little oil of cloves.—*Pacific Med. Journal.*

Freckles can be removed, according to Hager, by the application every other day, of an ointment composed of white precipitate and sub-nitrate of bismuth, each ℥i; glycerine ointment ℥ss.

FRACTURE OF THE SKULL, WITH PROTRUSION OF BRAIN SUBSTANCE AND REMOVAL OF SAME.*

W. R. GOOGE, M.D., Abbeville, Ga.

It is only recently that intrusion on the brain and membranes has been attended by so small a morality; but, owing to the great success and progress which has been achieved in antiseptic surgery, it is now of common occurrence.

It is not the purpose of this paper to let new light into the subject of brain surgery, but simply to corroborate the fact that if thorough cleanliness and strict astiseptic precautions are strenuously observed, the time will come and to a certain extent now is, that the surgeon may penetrate the most secluded recesses of the human mechanism and perform wonders which were not long ago shrouded in obscurity.

The time has been, and not long ago, when the idea was prevalent that intrusion on the brain or membranes was attended by almost certain death, or to penetrate the abdominal walls and peritoneum was considered folly of the most aggravated type, but thanks to the promulgators of antisepsis, we can now with impunity perform operations of this nature with a very low per cent. of mortality, which none dare to dispute. It is a boon to humanity and should be a source of self-congratulation on the part of every physician.

Fracture of the cranium with protrusion of brain substance and removal of the same, with recovery, is now regarded among the laity and also among some of the practitioners of medicine, as an impossibility, and it is the intention of the writer to disclose the results of a case of this discription and to show, if any doubt exists, that recovery in such instances is of very common occurrence.

On December 18th of last year, Mr. A. B. Pemberton, while guarding convicts for the Ocmulgee Brick Co., at Abbeville, Ga., was struck with the eye of a common club axe, on the posterior portion of the skull near the articulation of the occipital and parietal bones, the blow resulting in a complete fracture with the bone depressed and resting in the brain substance. The depressed bone had loosened quite a quantity of the brain, which, after observing the usual antiseptic precautions, I very carefully removed. It weighed just a little over half an ounce. After carefully removing every particle of matter that could possibly be foreign, I raised the skull with a common elevator to its proper position and placed it in apposition, after which I dressed the wound with iodoform gauze, packing the wound in order to prevent its healing externally; after which he was carried home and put to bed. Strange to say, he could walk and talk sensibly, still he had no recollection of the matter afterwards.

December 19th. Temperature 100° F. Absence of sensation, not being able to feel the prick of a pin; mind wandering. Gave sulphate of quinine and ordered an enema warm soap-suds and water every day.

December 20th. Temperature 101° F. Slight sensation; able to talk but would lose the subject.

December 21st. Temperature 100° F. Sensation returning and complaining of pain in left arm. Wound was right side of head.

December 22d. Temperature 90½° F. Pain more severe on left side. Sensation almost restored. Gave hypodermic of morphia and atropine.

December 23d. Pain gone. Sensation restored, and appetite good. Had eaten nothing since injured, being very much nauseated all the time.

December 25th. Temperature normal. Dressed wound and, strange to say, found no pus whatever. Patient able to sit up for dressing wound.

December 27th. Patient walked up town a distance of one-quarter of a mile, contrary to my directions.

January 1st. Bone had healed and removed packing from wound.

January 5th. Wound granulating nicely.

January 10th. Discharged patient with the wound almost well.

January 28th. Patient thoroughly well and accepted a position on S. F. & W. R. R. as section master.

*Read before the Georgia State Medical Association, April 19, 1893.

The question might naturally arise, are you sure that you removed the brain substance? And in reply I would say, that I never was surer of anything in my life, and can corroborate every assertion by my associate, Dr. A. R. Royal.

PERIPROCTITIS WITH AN ABSCESS AND REPORT OF A CASE.*

M. L. CURRIE, M. D., Mt. Vernon, Ga.

Periproctitis is one of those infrequent inflammatory diseases which the general practitioner may at any time be called to treat, and which he may fail to recognize until much damage to his patient ensues. If properly diagnosed, it may then be improperly treated, owing to the fact that he cannot always find such a precedent as he needs.

It is usually suppurative in character, but a cure may be effected by absorption, even after a distinct tumor is formed. Of the causes of this disease but little can be said. It may result from traumatism, foreign bodies, extension of adjacent inflammatory processes, or any structural disease involving the mucous membrane of the rectum. The manner of its extension and the course of the morbid processes excited, are identical with those seen in perityphlitis following typhlitis.

The prognosis depends much upon the time when the case is diagnosed, the treatment of both the inflammation and the abscess as well as the physical condition of the patient. When the vitality is low, and the abscess high up in the pelvic cavity, or when the patient is tuberculous it is unfavorable; when otherwise, we may hope for recovery. The diagnostic symptoms and the treatment I will give in connection with the following case.

Case I. Mr. G. B. A., aged 37, weight 200 lbs., very muscular and stout. On the 26th of January last he applied to me for treatment, stating that he had "piles;" that he was going to visit a sick relative in North Georgia, and would be gone two weeks; presuming that he knew his trouble, and without any examination, I gave him the usual prescription to regulate the bowels and an ointment for the hemorrhoids.

On the 18th day of February, I was called and found my patient in bed with a temperature of 102°, suffering with intense pain in and around the rectum; with tenderness of the whole pelvic region. On inquiry he gave me the following history:

On the 6th day of January last, while in the act of defecating, a severe pain was felt low down in the pelvic cavity on the left side, which continued daily, and which was always worse when bowels moved or during exercise. During his entire visit the pain was incessant. The medicine prescribed by me failed to relieve him, and, while riding on the cars, he was unable to sit erect, owing to the pain it caused him. Having carefully examined him, I found some induration of tissue and slight swelling, with heat and much tenderness, below Poupart's ligament on the left side. The sphincter muscles appeared to be spasmodically contracted and the tenderness around the anus was so great that I could not by the use of a 4 per cent. solution of cocaine introduce my finger into the rectum.

For this condition I advised rest in bed, and gave for the pain, morphine and atrophia hypodermically; for the fever, phenacetine and quinine; for the bowels, solution of sulphate magnesia with aromatic syrup of rheubarb and enemata of warm water; for the tumor, I applied warm fomentations.

February 19th and 20th the swelling in left side gradually increased until a tumor as large as a walnut could be distinctly outlined, for which I applied warm starch poultices every two hours. On the morning of February 21st, I discovered that the tumor had greatly diminished. In the evening, with the assistance of Drs. McCrimmon and Summerlin, I made a careful examination, under an anæsthetic, both digitally and through a rectal speculum and could discover no signs of a tumor or abscess except the inflammation. During the next three days, the inflamma-

*Read before the Georgia State Medical Association, 1893.

tion increased, the pain became more severe, attended with constitutional depression and inability to urinate.

February 25th, assisted by Drs. Rogers and Summerlin, I again anæsthetized the patient, and with difficulty I felt the lower edge of a fluctuating tumor protruding into the bowel at the apex of the ischio-rectal fossa, which probably pressed upon the urethra and rendered it necessary for me to use the catheter to empty the bladder.

With the index finger of my left hand resting against the edge of the tumor through the rectum, I passed a medium sized trochar parallel with the bowel straight up for four inches. The opening was then enlarged with a long bistoury and a pair of dressing forceps. Almost a half pint of foul looking pus escaped, having the odor of fæcal matter. The abscess cavity was then cleaned out, and iodoform gauze introduced and the part dressed with absorbent cotton. From the time the operation was performed the abscess discharged freely until the 28th, at which time the gauze came out and with difficulty more was introduced, owing to resistance on the part of the patient. During this time the patient was restricted to fluid diet and a tonic of iron and arsenic with quinine administered. On March the 4th, I introduced a small rubber tube in place of the gauze, which was necessitated by the healing of the wound.

On March 8th, the discharge had about ceased, and the opening to the abscess closed. The patient was suffering with pain, attended with fever and the presence of former symptoms, which increased until the 10th. At this time, assisted by Drs. Rogers and McLeod, I reopened the abscess, with my finger removed all septa of broken down tissue, and washed out the entire abscess cavity with an antiseptic solution of carbolic acid. A soft rubber drainage tube was introduced and the parts dressed as before.

The abscess discharged freely and patient slowly convalesced, but on March 14th, it was discovered that the water injected into the rectum partly passed out at the tube through the abscess.

At this stage of the case my judgment was severely tried to decide whether to subject my patient, who was at this time very weak, the fourth time to the depressing effects of an anæsthetic and sever such important structures as existed between the two openings, or wait for the abscess to heal and then operate for the fistula.

At the suggestion of an experienced surgeon, I waited, and to my pleasant surprise my patient is now able to be with me in this city and is well of both abscess and fistula without an operation.

I report this case hoping that, by so doing, I may be the means of relieving suffering humanity in similar cases through the agency of some one or more of my professional brethren. I believe it would have been better surgery for me to have opened the abscess through the rectum and I know it would have been better when I first opened the abscess to have made the incision larger and removed all septa of broken down tissue.

HEADACHE VERSUS GLAUCOMA.*

W. L. BULLARD, M. D., Columbus, Georgia.

"These medical sciences stand at a stay, and have done for years," so said Lord Bacon in the sixteenth century. But, could he step forward to-day and look over the literature that has been produced and brought forward relative to my theme, I am quite sanguine that this rare philosopher would change his assertion, partly at least to say that medical science is still a little slow in finding any one remedy as a certain relief for all kinds of headache, but it has reached the highest pinnacle of fame as to cause. The wise men tell us of an anemic, an hyperemic, or congestive, a nervous or cerebral, the toxic, and the bilious or sick headache, all of which have an abundance of causes. The oculists say that most cases

*Read before Georgia State Medical Association, April 21, 1893.

are caused from eye strain, but the gynecologist goes the eye specialist one better, and swears that nearly every case is reflected from uterine or ovarian irritation, while not a few cases are doubtless caused from urethral contraction, and syphilitic lesion of the brain or nervous system, so says the genito-urinary surgeon, and the general practitioner knows full well that nine cases out of ten are caused from a torpid liver or a gastro-duodenal catarrh. Now, gentlemen, ignoring every form of which we have spoken, including the headache the most of us will have the morning following the banquet, I will proceed to tell you of the kind of headache I wish to call your attention to, which is a headache, or possibly more often called neuralgia, a pain caused from and a symptom of a most serious disease of the eye—glaucoma. We have the acute and chronic; in the acute the eye ball becomes red and very much inflamed, with a hard tension of the ball as to touch, a dilated pupil, deep anterior chamber, and a cloudy condition of the aqueous humor and vitreous body accompanied with nausea and vomiting, at times pronounced as a bilious attack. A patient with this kind of headache or neuralgia, suffers at times with the most intense pain extending into the eye from the brow on the nasal side with an œdematous condition of the lid. In the chronic form, it sometimes runs its whole course without causing any excessive degree of redness or inflammatory condition of the ball, and the vitreous and aqueous humors are transparent, rendering necessary an ophthalmoscopic examination with which the pathognomonic excavation of the optic nerve may be readily seen; yet the patient at times suffers intense supra-orbital pain. The storm after a day or so may pass off, but is sure to return at shorter or longer intervals, and the intra-occular tension slowly, but surely, does its destructive work upon the optic nerve fibres until the "windows of the soul" are forever closed. In true supra-orbital neuralgia or, as it is designated by the laity, "sun pain," the suffering is quite severe, the ball red and the supra-orbital notch very sensitive to the touch, but the pain is paroxysmal, beginning in the morning after sunrise, increasing for a few hours, and gradually subsiding in the afternoon before sunset, to begin the next morning possibly a little later than it did on the preceding day. You will find the vision not impaired, the cornea clear, the pupil normal in size and readily responding to the influence of light, which is not the case in the glaucomatous form of headache, and under the treatment of antipyrine, quinine and arsenic the paroxysm is soon checked or broken. While there is some similarity between the two diseases, the differential diagnosis is easily established, yet I am afraid that most physicians have no idea how many human beings are to-day from a mistaken diagnosis, groping their way with vision irretrievably lost, and the victim left as in Milton's soliloquy.

I only wish that I was able to protray to your minds the true realities of which I speak. In an effort to do so, allow me to quote from a lecture delivered at the Chicago Policlinic by that eminent Chicago oculist, Dr. F. C. Hotz: "Gentlemen, it is the fact that the severe neuralgic pain, and the violent gastric disturbances, induced by acute glaucoma, have been taken and treated for "rheumatic or malarial" neuralgia, while the ocular disease has not been recognized until too late. I have seen several cases of this mistake; one was an especially sad case which impressed me so much that I shall never be able to efface its picture from my memory. Though fifteen years have gone by since I have seen the unfortunate patient, her image is before me now as vivid and distinct as if I had seen her yesterday. Two months before I saw her she had been seized with fever, nausea, frequent vomiting, and violent pain extending over the entire left side of the head. Her physician pronounced her trouble to be gastritis, and "sick headache," and when the old lady called his attention to the fact that her sight was getting poorer every day (and she could see with her left eye only; for the sight of the right eye had been destroyed by glaucoma ten years) he assured her she need not worry about it; that her sight would return as soon as the stomach trouble was cured, and the neuralgia in the head relieved. Having implicit confidence in her physician she believed his word, and though her sight soon had vanished completely, she waited hopefully for the day when the darkness would be lifted again from her eyes, and patiently endured the constant, most violent headache, which

robbed her of rest and sleep by day and night. For two weary months this poor woman suffered, and hoped; but then her patience was exhausted and much against the will of her physician she went to consult an oculist. Poor woman! it was too late. The continued high tension of glaucoma had done its deadly work upon the optic nerve too truly, and although the iridectomy effectually reduced the intra-ocular tension, and promptly relieved the patient of the terrible headache so that after the operation she could enjoy a good quiet sleep for the first time in eight weeks, the woman has never seen a ray of light since the awful result of a mistaken diagnosis." Now, gentlemen, I venture the assertion that there is not an oculist of any experience, so to speak, who has not seen cases similar to the one just quoted, and I will quote from a letter bearing on this subject received since I commenced to write this paper. It is by Mr. J. M. Floyd, of Fayetteville, Ala., who says that: "I write you concerning my wife, who has been blind for two years. She is fifty-seven years old; in very good health. About three years ago she was taken with neuralgia in the head, which settled in her eyes; the misery was very intense for some months, after which she became nearly blind. She lost all sight about six months afterward. I took her to an oculist who pronounced it glaucoma, and told her that he could do her no good." Now, I don't know the cause of the delay in this case but am sanguine to say that had there not been a mistaken diagnosis the delay would not have happened, and to-day there would have been one less blind person groping about in the long dark night. May I ask why this mistaken diagnosis? Is it from the fact that we become careless in making our examination, and take too much for granted in what our patient tells us? In truth sometimes do we let the patient make the diagnosis? But who is responsible? The diagnosis is correctly made, the only remedy is the surgeons knife, and the sooner the iridectomy is done the greater the chances for the restoration of vision. No known medical treatment, including Dr. Hammond's cerebrine and medulline, can permanently stay the disease. Physostigma and pilocarpine will check the destructive ravages for a time, giving the afflicted some chance until the surgeon can be seen. Preparations of belladonna, and erythroxylon cocoa which includes cocaine, should never under any circumstances be used in glaucomatous headache, and permanent good need not be expected from any treatment save an iridectomy, as advised by Dr. Græfe some years ago, and which I must add, is one of the grandest triumphs of modern surgery.

SOCIETY REPORTS.

STATED MEETING OF THE CLINICAL SOCIETY OF LOUISVILLE.

Meeting, April 18th, 1893.

Dr. John G. Cecil, President, pro. tem. in the Chair.

TWISTED UMBILICAL CORD, CAUSING DEATH OF FŒTUS AT SEVENTH MONTH.

Dr. P. Gunterman: I have a specimen here which is very small and seemingly very insignificant; still it caused the death of a baby. A woman came to my office about two months ago, who was then seven months advanced in pregnancy. The day previous to her visit to my office she sustained a severe fall; however, she said that she got up and went about her work not feeling any serious inconvenience, but from that time she has not noticed any movement of the child. As there were no distressing or unusual symptoms, I advised her to let matters take their course and await results. She went on in that way until about ten days ago, when I was called in the evening to deliver her. I found her in labor, the bag of waters protruding and the os well dilated; found a small head presenting; ruptured the bag

of waters and there was but a small quantity, 1½ pints to a quart all together, which was clear and not fetid. Delivery was accomplished without difficulty and the placenta came away promptly. I found that the baby was dead, probably at about the seventh month, but was not macerated. When I tied off the cord I noticed close to the body a shriveling of the cord; upon closer examination I found this little specimen and cut it off. Evidently the child had died from the effects of the mother's fall, making several turns, twisting the cord close to the abdomen and the constriction thus produced stopped the circulation.

P. Gunterman, M. D., then read a paper on

CHLOROFORM ANÆSTHESIA AND ITS ADMINISTRATION: PART SECOND.

At the previous meeting I had the pleasure of reading about the administration of chloroform. Purposely the anæsthesia from ether was not touched upon. Ether has been used by me comparatively but a few times; chloroform quite frequently. And since these remarks are made mainly to solicit discussion, there is no reason why the ether question might not be also discussed.

The remarks this evening having been very hastily jotted down, only, to my mind, the most salient points have been considered.

Chloroform, if it does kill, does so either abruptly and suddenly or gradually and by degrees. Chloroform is an irritant specific narcotic, one of great diffusibility and capable of quick and excessive action. On the other hand it is progressive in its action, and when administered in proper dose, gradually, the patient is not apt to die from an overdose, but if he does the end may not come so slow as from other narcotics and as from ether.

A person to be chloroformed and made ready for an operation is naturally often unduly excited, because of the chloroform and because of the operation. Such a state of mind is very dangerous and great caution ought to be exercised less we have spasms of the respiratory muscles, failure of respiration from paralysis or syncope. Death may come after the first few whiffs or later, sometimes even after the administration has long ceased and the patient is thought to be recovering. Strong, healthy and robust (especially stout) people who take chloroform for the relief of pain from small troubles, are prone to have syncope. People otherwise constituted, when given chloroform for a short time and short of abolishing completely actual pain, do not often, if ever, have fatal syncope.

We must, as stated the other night, pay close attention to breathing, pulse, the reflexes and the approach of cerebral anæmia. Danger is near from this last source when you notice a peculiar pallor of the face and particularly about the lips, which are firmly drawn, so as to expose the teeth, and give to the countenance a most ghastly expression. The operator may notice, before the chloroformist, that the patient is in danger when the flow from the bleeding artery stops. Change in respiration, faltering of the pulse, and unusual and persistent dilitation of the pupils are indicators of danger. It is said that a patient under the influence of an anæsthetic is at the threshold of death, and a very insignificant peculiarity of his may settle his fate. They do, however, not all die from the effects of the anæsthetic, at any rate conclusive proofs fail as yet. On the other hand people have died on the operating table who have taken no anæsthetic. A patient who dies while taking chloroform may die from other causes.

Patients may die under anæsthesia from heart failure, by paralysis of the respiratory centers, from cerebral anæmia, and from shock. Deaths from heart failure and cerebral anæmia are perhaps the most frequent. If chloroform is to be blamed for all the mishaps ascribed to it, how do we explain the fact that, of the hundreds of thousounds of parturient women, who have taken it, not a single authentic fatal case is on record. It is claimed that their state of mind just fits them for taking the chloroform, that they just suffer enough pain to prevent syncope and that straining at every succeeding pain keeps the brain well supplied with blood. Such is good reasoning. We might, perhaps, conjecture that it is ordained by an all-wise Providence, who is said to have condemned woman to bear her children in pain and agony. These facts ought to serve as proof, to an unbiased

mind, that other agencies and conditions are at work to make chloroform—if you will, any anæsthetic—a bugbear to the operator and cause unjust censure to the administrator for mishaps.

If now accidents do occur, as they have done heretofore, be calm, be cool, be collected, and be deliberate. Have your means of resuscitation at hand. Have your stimulants, brandy, ammonia, nitrate of amyl and nitro glycerine, have your hot bottles and by all means your battery. Be ready to institute vigorous and prolonged artificial respiration. Pull the chin forwards, upwards and with it the head backwards and forcibly draw the tongue forwards. If this mild form of artificial respiration does not succeed use any of the other established methods. Electricity is the great mover and stimulator of the respiratory muscles and nerves, and quite a number of cases are on record where its proper use brought about the desired result. Laryngotomy has been done to re-establish respiration. To relieve anæmia of the brain, reverse the condition of affairs and put your subject in the perpendicular (almost) with the head down. Twice have I seen life come back in a body breathless, pulseless, and apparently dead. Men of worth have fought this method and others as warmly defended it.

Permit me a little pleading for small stimulating doses of morphia, atropia, either—all things being equal—before or after the administration of chloroform. They may produce a general quietude, they may stimulate the heart's action and raise the blood pressure sufficiently, perhaps, to overcome undue depression from the chloroform.

In conclusion: Whenever it becomes necessary to use means of revival be persistant, methodical and—keep on.

DISCUSSION.

DR. WM. CHEATHAM: It is a fact that we do have deaths occasionally from chloroform in the hands of the most careful men, men who make a specialty of anæsthesia. For instance in England, you can refer to almost any issue of the *London Lancet* and it is not an uncommon thing to find from one to five deaths recorded from chloroform, in charge of those making a specialty of this work, showing that there is danger in chloroform outside of the administrator.

As to the method of death: I believe the rule is that patients dying from chloroform anæsthesia die suddenly and we have no time to make an effort at resuscitation. The two facts that we do have deaths from chloroform in the hands of careful, experienced men, and that such deaths are generally sudden, I think is against its administration. On the other side, you take ether in the hands of a man who is accustomed to giving it and if there is any trouble from its administration it comes on in such a manner as to give a man time to make an effort to save his patient. Some years ago I gave ether for a gentleman in New York, and the patient came near dying three days afterward from kidney complication. He was taken sick immediately after the administration of ether and was in a serious condition for three days, then made a good recovery. With chloroform, should there have been trouble, death would likely have come suddenly, and we would have had no time to make an effort to save the patient. In view of these facts I think ether the safest anæsthetic of the two. We have had in this city within the last year, I understand, six deaths from chloroform, all of them occurring before any instrument was used, while preparations were being made for the operation. Some years ago I saw in the city hospital a man who had taken chloroform eighteen times before for the same trouble, (dislocated shoulder) and the nineteenth time he died; death was sudden after taking only a few whiffs of chloroform.

In my practice I use, as you know, very little general anæsthesia, and in recent years I have not had much experience in the use of either chloroform or ether. However, with over three years' experience in the New York Hospital, giving ether three or four times per day, I only saw one accident. Some men admit that the reason they advise against the use of ether is not that it is more dangerous than chloroform, but because it is more disagreeable to the patient. While there may have been some cases where nausea was attributable to ether, still I believe if it is thoroughly watched you are no more liable to have nausea from it than from chloroform.

DR. A. M. VANCE: I think one of the most important parts of surgical work is the consideration and choice of an anæs-

thetic and the person who shall administer it. I know of no other element in the life of a surgeon that gives him more anxiety and more trouble. I use both ether and chloroform, and my choice, except where there are special indications for giving one or the other, is governed entirely by the man who is to administer the anæsthetic. There are men who know how to give chloroform, who practically know nothing in the world about giving ether, and vice versa. Therefore, I think in general surgical practice when we have a man as anæsthetist who knows how to give chloroform and does not know how to give ether, our choice should be chloroform. On the other hand, if we have an anæsthetist who is perfectly familiar with the giving of ether and does not know how to give chloroform, we ought to strain a point in favor of ether, or get somebody else to administer the anæsthetic. I think it is the duty of every operator to require the patient to admit a man of experience as anæsthetist, and we ought as operators to demand a remuneration for that service. I have never seen a death from anæsthetic, that is one that I could say was directly caused from the administration of either chloroform or ether. I have had two deaths on the table in my whole experience, both of which I believe were caused by shock. Both patients were women, one an old lady who had cancer of the lower jaw—a very horrible condition; she was a horror to herself as well as to all her friends; the tumor was protruding from her mouth, producing a condition of druling which was horrible in the extreme; she died just at the close of the excision of that part of the jaw including the growth. Post mortem examination revealed the fact that she had a metastatic condition of the mesenteric glands, liver and probably of the kidneys. She failed to take any stimulation prior to operation, which was advised. The other was a younger women who took ether; the operation was abdominal hysterectomy; patient died just at close of the operation. I want to mention one other case that died a few days after operation for ventral hernia. This patient had slight bronchial trouble; she had been subject of four or five attacks of pneumonia and had lateral curvature. She died three days after the operation from a septic condition seemingly due to the large accumulation of pus apparently in the bronchus, the abdominal wound doing nicely.

Dr. Gunterman's remarks as to the responsibility are not carried out by my experience or by what I have heard in discussions of this matter. He speaks of the anæsthetist being blamed or held accountable for the results in these cases. I think the anæsthetist is rarely blamed for accidents of this character, but the operator is the man who bears the brunt of responsibility. This is very natural, because people look to him for the final outcome of the case. I agree perfectly with Dr. Gunterman that where we have fear and excitement on part of the patient in regard to taking chloroform, we are more liable to have trouble. My experience has been that the administration of morphine or atropine, morphine especially, has some disadvantages. The patient is a longer time in waking up usually and though the condition may be good, it causes a great deal of anxiety on the part of the family and retains the physician there a long time, where it really is unnecessary. I question whether whiskey given with atropine would not be better—I always give whiskey hypodermatically during the operation if at all indicated; rarely give by the mouth before hand.

I also disagree with Dr. Gunterman in the statement that operations done under partial anæsthesia are usually followed by no aggravated symptoms. My experience is that these cases often have more depression and more shock than those where complete anæsthesia is present. It is better to give the anæsthetic to completion rather than do an operation under primary or partial anæsthesia. I would like to emphasize the statement that I think it is our duty, as operators, to require the employment of a man recognized as an anæsthetist, so it may be said, if we do lose a patient, that we had a man of experience for the administration of the anæsthetic, although it may sometimes offend the family doctor or patient who has chosen the administrator of chloroform because of friendliness; this is often the cause of complications, owing to inexperience or lack of knowledge of many men in the administration of chloroform. I think the choice of an anæsthetic should be to the greatest degree determined by the experience of the man whom you are

obliged to accept as an anæsthetist, being of course governed to the proper extent by the special indications in each case; all patients having suspicion of lung or kidney trouble being given chloroform, all those having heart troubles being given ether.

DR. J. M. KRIM: My experience in this direction has been almost entirely with chloroform. I have never seen any unpleasant symptoms, excepting in one case, and have had no deaths. I have had little or no experience with ether, and cannot see why it should be perferable to chloroform. Of course the majority of cases in which I have had occasion to use chloroform have been obstetrical cases.

In regard to a special anæsthetist: We are very frequently placed in a position where it is impossible to obtain such a person, and we have to accept just such assistance as we are able to secure. I have often started the anæsthetic and let a midwife or some one else finish it. Fortunately, I have never had an accident, but of course no one can tell how soon it will come.

DR. GEO. W. GRIFFITHS: I am still a strong advocate of chloroform as against ether. I cannot give statistics, but as stated at the last meeting of this society, I saw chloroform administered to hundreds and hundreds of men in the late war with only one death that could possibly be attributed to the anæsthetic.

There is one very important point that Dr. Gunterman did not mention in his paper, that is to have blocks or bricks in the room to elevate the table at the foot. I know at the Sts. Mary and Elizabeth Hospital I came very near losing a case that I was about to operate on, some time ago, owing to delay in procuring something with which the table could be elevated in this way. Now we have very high blocks always ready to be placed under the table, which very materially lessens the danger. It may be that I am wedded to chloroform because I have had very little experience with ether. I must admit that since I have seen Dr. Guest administer ether on a great many occasions, I am more favorably inclined toward its use than ever before.

In regard to the deaths that have occurred in this city recently and elsewhere: It is barely possible that the chloroform might be blamed for it, on account of some impurity. We were preparing to operate some time ago, Dr. Guest will remember the case, and sending to the drug store for ether, they sent us chloroform. It is probable if Dr. Guest had administered the chloroform in the same manner that ether is given (excluding the air), the patient would have been dead. It was a first class druggist or drug store that sent us the chloroform, and his excuse afterwards was that he "did not have any ether, and chloroform was just as good." You must analyze the whole thing, take into consideration the various advantages and disadvantages, previous health, surroundings and everything of that kind in making up your statistics in your condemnation of chloroform.

As far as having a special man to administer the anæsthetic is concerned: This would be impossible in some of my work. My operations are largely "emergency surgery" and I have to pick up the most suitable person I can to give the anæsthetic. However, I think we ought always to agree upon a special man to do that work in the city, where it is possible.

DR. P. F. BARBOUR: I believe most of the points have been covered in the discussion this evening and two weeks ago. I believe in children, especially young children, chloroform should be used, as it is much safer than ether. In obstetrical cases chloroform should be used; it is very much pleasanter and is not objectionable on account of danger.

Where you have light or heat from a stove near the operation chloroform is indicated, but recent investigations tend to show that chloroform is not entirely safe in close proximity to a flame. The burning of a candle, for instance, seems to convert chloroform into hydrochloric acid and lower chlorides of methane which produce intense irritation of the bronchial membranes, affecting the operator as well as the patient. There are several cases of that kind on record. In military service, I suppose chloroform is much the better because you can work very much more rapidly with it; it is much easier to carry around, and is perhaps safer, as you have not time to inquire whether the patient has kidney, lung and brain trouble.

I would like to call attention to the method McBurney has suggested for giving chloroform or ether; that is by putting an Esmarch bandage around the

limbs and in that way the ether or chloroform is absorbed by only a certain portion of the blood, then when you remove the ligature you have a fresh supply of blood, the patient comes out from under the anæsethetic very quickly, and it also has the advantage that patients can be gotten under the influence of the anæsthetic very rapidly. I saw McBurney put one patient thoroughly under the influence of an anæsthetic in two minutes, and she came out in about the same time.

In regard to the treatment of chloroform poisoning: Electricity of course, is good, also alcohol and digitalis. I prefer strophanthus to digitalis as it is much more rapid in its action. Dr. Gunterman failed to mention one very important aid in the treatment of chloroform poisoning and that is hot applications over the heart; nothing stimulates the heart so much as hot applications.

Speaking of children: I saw Dr. Abbe operate upon a child aged twenty months, in New York, for sarcoma of the kidney using ether as an anæsthetic. I have always thought that was placing the child in very great risk of its life. It had only one kidney by which to eliminate the ether, and it seems to me a strong objection could be raised against the use of ether in cases of that kind. I do not know the subsequent history of the case.

Dr. J. W. Guest (Visiting): All the accidents I have seen from chloroform anæsthesia, which numbered seven and one death, have been very rapidly produced, and I believe this is the rule. In regard to the six cases, referred to by Dr. Cheatham, that died before a knife was used: I do not know of the other five, but do know of one. In this case the operation was completed and the chloroform cone thrown away thirty seconds or more before any serious symptoms were noticed. All at once the heart began to fail and, although every effort was made to save the patient, she died very quickly, and from cessation of the heart's action. Her respiration continued good for several seconds.

Dr. A. M. Vance: Was the patient thoroughly under the influence of the anæsthetic at the time of the operation?

Dr. J. W. Guest: Her conjunctival reflexes had disappeared, stertorous breathing supervened and she was apparently sufficiently anæsthetized for any operation. In fact, she was more thoroughly anæsthetized than the majority of cases to which I administer an anæsthetic, yet not profoundly under it, for during the divulsion she evinced a slight pain.

I believe Dr. Gunterman, in his paper, stated that oftentimes the operator would notice serious symptoms even before the anæsthetist. I can scarcely conceive how this could be if the operator is absorbed in his work and the anæsthetist in his, unless purely accidental. It is usually the case that the anæsthetist is the first to detect serious or unusual symptoms of the heart or respiration, which are not noticed by the operator until his attention is called to them.

I am not an advocate of chloroform, neither am I a confirmed advocate of ether, but believe each case should receive a careful examination and the anæsthetic selected which is most suited to the case. I believe, that in time, other anæsthetics will be discovered which will be found more suitable to certain conditions in life than those we are now using, just as morphine has given way to other drugs. Of course, morphine is still preferable in some conditions, while in other cases there are other drugs which give us better results. I do not think we have a right to say that we will give chloroform or ether, irrespective of the patient's physical condition, surroundings or of consequences. There are many things to be considered. I believe, however, the majority of patients will take ether better and that ether is more suited to the majority of patients than chloroform, especially in extended operations, because it produces by far the less shock and gives the patient a better power of surgical resistance by stimulating, instead of depressing, the system as with chloroform. I want to record myself as believing that chloroform is contra-indicated in every case where ether is not. We should give our patients every possible chance of a safe anæsthesia, and, in view of all statistics collected, I do not see that we can claim that for chloroform. Julliard, of Geneva, in his statistics, reports one death from anæsthesia in 3258 cases where chloroform was used, and one death in 14,987 cases where ether was employed. Nearly five deaths from chloroform to one of ether, and still there are some who claim that chloroform is the safer anæsthetic. In chloroform anæs-

thesia we often hear of serious accidents and difficult resuscitations; where ether is used we seldom hear of these, and yet these accidents are never considered in compiling statistics.

Dr. Jno. Cecil: I feel the burden of responsibility in cases of anæsthesia with any kind of anæsthetic, about as much as in any other situation that comes up in the practice of medicine or surgery. For that reason, I believe the anæsthesia should be in the hands of a competent and experienced person, and he should be well paid for his services. I am inclined to believe that for general anæsthesia, ether is the safer. I do not very well see how we can get around the statistics on this subject, and as has already been mentioned, the method of death and our ability to cope with it, makes ether the safer anæsthetic. Of course, there are always certain general indications to be taken into consideration in the choice of an anæsthetic, but all things being equal I believe ether should have preference. In the majority of obstetrical cases I think chloroform is the safer. Ether, because of its stimulating properties, should be used in the management of cases of severe hemorrhage where any anæsthetic is required. I am inclined to believe there is more danger in the administration of chloroform in obstetrical practice than is usually accorded, and unless I am mistaken, Lusk, in his recent work, reports several cases of death from chloroform in connection with obstetrical work.

The different points have been so thoroughly discussed, that it is unnecessary for me to repeat anything that has been said, but since the last meeting of this society I have had an experience with chloroform that has been the source of considerable anxiety. The case briefly is this: Last Friday, Dr. Frank asked me to see a lady about twenty-five or thirty years of age, who had had a miscarriage and had subsequent hemorrhages more or less profuse in quantity. The patient was the mother of two children. She had some suspicion of lung trouble, perhaps development of phthisis, not well-marked. The patient when I saw her, seemed to be apparently well nourished, color fairly good, considering the quantity of blood which had been lost in several hemorrhages previous to my seeing her. I advised curetting of the uterus; she had been delivered with forceps and had had one previous curetting for some trouble following an abortion a year or so ago, and had conceived a most intense fear of all instruments. I thought a blunt curette would answer every purpose and told her that I believed such trouble as existed inside the womb might be relieved by this means without the administration of an anæsthetic. We found, however, that we could not proceed until we had given an anæsthetic. I had a bottle of chloroform which I had reason to believe was Squibb's chloroform for anæsthesia, bought from a careful druggist. Dr. Frank proceeded to administer this chloroform, giving it to complete anæsthesia; I will say, however, I introduced the speculum and was making the necessary preparations for curetting before she was completely under the anæsthetic, but nothing was done in the way of curettage until she was well under the influence of chloroform. I proceeded as rapidly as possible to curette every part of the uterus, the operation probably not occupying more than seven minutes, but before I had finished the work to my entire satisfaction, Dr. Frank called my attention to the fact that the patient was not doing well, stating that she had ceased to breathe. I asked him the condition of the pulse, and he said then it was fairly good. I immediately withdrew the speculum and curette, and found her with a very weak pulse, perhaps 120 to the minute, and not breathing at all. I had seen people stop breathing and was not particularly anxious about it, but concluded to suspend operations until we could revive her. We grasped the patient each by one arm and leg and let her head drop over the edge of the bed when she immediately gasped and commenced to breathe from that time. After straightening her around on the bed, I felt the pulse and found it much better, probably beating at the rate of 100 or 110 and pretty fair in volume, and again I felt relieved as to the situation, concluding that it was simply one of those little fainting spells which sometimes occur under anæsthesia and was about to proceed when I noticed that she had ceased to breathe again; she would take one deep breath then respiration would cease for half a minute, or perhaps a minute. The most remarkable thing about it was the pulse ranging from 100 to 150 per minute, it would change

from a full round soft pulse in two minutes to a very weak, thready or rapid pulse. This thing kept up and we immediately commenced the administration of restoratives, giving her atropine first in $\frac{1}{150}$th grain dose, which had no beneficial effect, then in two or three minutes we gave her nitro glycerine and digitaline in the same hypodermic, keeping up artificial respiration. Every little while we would tip her over the side of the bed and each time would be rewarded by seeing her come around very promptly, but in a few minutes she would cease to breathe again, and the pulse would likewise fail. We then gave her a hypodermic injection of brandy and placed hot bottles around her. This kind of treatment was persevered in for one and one-half hours before we could safely leave the patient; we finally did leave her in very good condition and had no further trouble in the case.

In my judgment, that woman came very near dying from chloroform, and we afterward learned that on the previous occasion, when Dr. Cartledge did the curetting, she had taken chloroform very badly and had experienced a number of fainting spells afterward. I have often seen irregular respiration under chloroform, but I have never seen the pulse vary as it did in this case. This patient seemed to be in more danger from respiration than from the heart. I simply mention the case as one which struck me as dangerous for the administration of chloroform, and one in which there will be danger every time she takes it. I do not know how ether would do in such a case.

Dr. Gunterman: I favor chloroform simply by preference. I use it a great deal oftener than ether. As far as I can see, it is utterly impossible to make accurate statistics as to the fatality of ether and chloroform, comparatively. There are for instance, forty thousand cases given by Nusbaum that are never taken into consideration in making up statistics; there are thirty-eight thousand cases of Esmarch's, and a great many others that reach into the thousands, that have never been considered in making up statistics; there are a great number of cases given by the ordinary physician, and by the small surgeons like myself, which are of course, not considered in statistics.

As to having a special man for this particular work: I said in my first paper that I did not advocate a specialist, but I said at the same time that every physician ought to be thoroughly informed as to how to give it or any other anæsthetic.

In regard to Dr. Vance's remarks that the operator rather than the anæsthetist bears the blame in case of an accident, I must differ: I have seen but one death from chloroform and that was many years ago. Dr. Cowling was the anæsthetist and Dr. Bayless the operator. The patient died very quickly after a few whiffs of chloroform. In this case, the adminstrator of the anæsthetic had to bear the entire burden of responsibility.

Another remark made by Dr. Vance of not giving morphine or atropine as a stimulant in these cases: I must differ with him in this, but I believe these drugs should be given in very small doses, just enough to stimulate the circulation or its action, just enough to produce a little quiet and not sufficient to produce prolonged sleep and in this way prevent us from seeing how our patient is coming from under the anæsthetic.

As to hemorrhage in obstetrical cases: I am satisfied that when you give chloroform in obstetric cases you always have a greater amount of hemorrhage than without it; where there is any danger of hemorrhage, where you suspect it, whether it be placenta previa or some peculiar condition of the woman, if an anæsthetic is to be given, let it be ether by all means.

Quite a sensation has recently been made in Boston by the successful application of wool-fat, or agnine, to the skin, for the removal of wrinkles. When applied with rubbing, it passes directly through the skin and acts as a nutrient to the fatty tissues beneath. An ancient dame has succeeded in removing nearly all the crows-feet from around her temple, and the remedy is fast becoming very popular.

The washing of the parts with ether is said to be a rapid and complete method of destroying pediculi pubis.

If you had to go to Heaven on the testimony of your dressmaker could you do it?

He who would be strong in mind must have facts for his diet.

THE MEDICO-CHIRURGICAL SOCIETY OF LOUISVILLE.

Stated Meeting May 12th, 1893.

THE PRESIDENT, DR. F. C. SIMPSON, in the chair.

DR. T. H. STUCKY: In making my round at the City Hospital this afternoon, I found this patient and the case struck me as being one of considerable interest, especially as to the diagnosis which seems to be very obscure. I will read the history as entered in the Hospital record by Dr. Rousey the Interne.

"J. R., residence Louisville, occupation baker; age fifty years. Father dead; cause unknown; mother died of old age. Number in family five, health good. On or about April 1st, was taken with vomiting and pain in the epigastric and hypochondriac regions; bowels regular at this time, but since has had alternate diarrhœa and constipation; stools yellowish brown, high colored. For last three weeks has been worse and noticed tumor in left hypochondriac and epigastric regions; suffered from insomnia, anorexia, coated, flabby tongue. Entered Hospital May 10th; temperature 101½° F; pulse 110; complained of headache and pain in abdomen. On examination found tumor which could be easily outlined by palpitation. When lying on back could easily detect pulsation synchronous with heart beat; tumor movable and gives apparent fluctuation; flatness on percusion; auscultation negative, unless lying on the back, then a transmitted bruit is given. Treatment, salines with big enemas; bowels moved well but not effecting the size or shape of the tumor."

This case seems to me to be of unusual interest. The tumor is very marked; was first noticed about six weeks ago, having grown very rapidly since. There is no history of jaundice.

DR. A. M. VANCE: I think there is an accumulation of fluid, either a cyst or abscess of the liver. I hardly think it the gall bladder.

DR. A. M. CARTLEDGE: I think there can be no doubt about this being the gall bladder distended with mucus and probably a little bile. It has every evidence of this trouble, tense feeling, fluctuation, etc. and besides it is pretty near the region of the gall bladder, reaching up nearly to the notch in the liver. Ten or twelve weeks ago, I had a case which somewhat resembled this one, except that it did not have the appearance of being cystic as this has. I made the diagnosis of distended gall bladder, cut down upon it and found it was a soft tumor of the omentum. I took out a section of it and the diagnosis was made, by the microscopist, of sarcoma. The most remarkable feature about that case is that the man has steadily improved since the operation, has gained in flesh and really looks as though he was going to get well. The wound closed without any trouble.

DR. D. T. SMITH: It seems to me that the tumor produced by a distended gall bladder would not have so sharp a contour in that position. Again, the other evidences, such as obstructed flow of bile, etc. are not present. There was a case in the City Hospital some years ago, when I was in attendance there, in which some distinguished physicians made an examination and every one of us missed the diagnosis. There was a tumor in the epigastric region and it looked very much like the case before us to-night. Aspiration was practiced on one or two occasions. The man died a few days afterward and the trouble turned out to be an abscess of the left lobe of the liver. I am rather inclined to that opinion in this case, although we know how liable we are to be mistaken in such a condition.

DR. DIXON (visiting): The case is one of great interest to me. The tumor evidently seems connected with the liver in some way. I do not think it is the gall bladder. I had a similar case in the person of a lady in our town, in which the tumor disappeared under purgative treatment and local applications of iodine. The tumor reappeared, I think, the third time, and each time disappeared under purgation and local applications of iodine. I examined her under an anæsthetic and could trace the tumor up to the notch of the liver, and I am almost certain it was not the gall bladder, neither do I think it was an abscess of the liver. In the case before us I think the trouble is probably abscess of the liver.

Dr. T. H. Stucky: I would like to have had some suggestions as to treatment in this case, whether it would be considered strictly surgical, whether it would be best to aspirate, perform a laparotomy at once, or further try the saline treatment. He was placed upon salines on the night of the 10th instant, which has produced no material change in the stools as to color or character. They have been a little more frequent and more watery. The question with me was whether it is strictly a surgical or medical case.

Dr. J. B. Marvin: In regard to the trouble being in the gall bladder: The point made by Dr. Dixon against that view I do not think is well taken. Not many years ago Dr. Larrabee had a case in a child, having a large tumor in this region which was tapped and reported as a case of abscess of the liver. I took issue at the time and requested Dr. Larrabee if the child died to allow me to be present at the autopsy. In the process of time the child did die and Dr. Larrabee and myself made the autopsy; we found over a quart of fluid in the gall bladder. The cystic duct was obstructed, preventing the flow of bile into the duodenum. The absence of jaundice does not necessarily figure against the idea that the trouble in the case presented is in the gall bladder. I am rather inclined to that view, that it is a distended gall bladder rather than an abscess. I have taken some little pains in looking up reports of abscess of the liver, and have never seen a case where there were not more marked extreme symptoms than this man has complained of.

Dr. A. M. Cartledge: I believe the only way to get at exactly what the trouble is in this case is by an exploration. In the first place, I do not see how it can be retro-peritoneal trouble. In the next place, it seems to be clearly cystic and there is considerable distension. In the third place, the history of the case, if it bears out anything, is one of empyema of the gall bladder. Jaundice does not play any part. This is the very kind of a case in which we have no jaundice necessarily. Probably a calculus has become obstructed in the cystic duct, and the gall bladder is distended with bile and mucus. The gall bladder might be distended in this way and the functions of the liver not interfered with.

CORRESPONDENCE.

POINTS OF SIMILARITY.

To the Medical and Surgical Reporter:—I have read the address of Dr Roberts, President of the Philadelphia County Medical Society, upon "Points of Similarity between Us and Homœopathic Physicians" with much distrust in the view advanced.

The burthen of his argument seems to be an apology for the Homœopathic system of medicine, with a wish to receive those who call themselves Homœopaths into fellowship with us.

Nowhere in his argument do we see the moral side brought out to sustain him further in his position. If, as the doctor gives us to understand, these Homœopaths adhere to their peculiar theory in self-limited and minor complaints, but in the graver forms of disease they resort to scientific medicine, the query arises, why do they not discard the name Homœopathy, and come out honestly and show openly to the public where they stand. This species of deception should meet with an open rebuke instead of receiving them into favor. In my observation of this class of Doctors, it has appeared to me that they run their calling for what there is in it financially, without any higher or nobler aim than business.

Where do we see among them any original investigators that have advanced the science of medicine. To-day real Homœopathy is nearly where it started. It was Hahnemannism in the beginning and it is nearly the same now. Does any one man perfect a thing? The past tells us No. The discovery of the germ origin of

diseases together with the many additions to our materia medica lately, and the elegant pharmacy of our drug houses have all combined to alarm them for the safety of their system. Hence they have had to resort to the trickery of trying to deceive the public by calling themselves Homœopaths while in truth the majority of them, the more successful ones, treat their cases scientifically without any regard to their peculiar theory.

A young woman who I met sometime ago, spoke to me of how soon a Homœopath relieved her of a violent headache. She said "he gave me a white powder and in 15 minutes my headache was all gone. The white powder proved to be Phenacetine, thus giving her to understand he used Homœopathic medicine for which Homœopathy received the praise. How can we tolerate this species of deception without a rebuke from us.

If Dr. Jos. Ribb and Dr. W. H. Holcombe told such views as Dr. Roberts gives them credit for why are they appearing as Homœopaths before the world. Have they not a purpose in it, in thus deceiving the public. The system having brought itself into favor mainly by the tasteless form of its medicines, it is resorting to many devices to keep its standing as a separate body. This immoral position the Homœopaths hold before the world, we as physician all see, but the general public are deceived and are not cognizant of it. Hence the large field of practice that many of them have. Having gained a notoriety for using, "easy to take" medicines, they are loath to give up their separate organization, for the system certainly has proved a financial success, as we all see. But can they long maintain this position before the world with this duplicity of action.

I have no doubt Dr. Roberts "*Heartiest handshakes*" would be returned with enthusiasm, for they have all to gain by it and nothing to loose. Therefore I would say let us keep aloof from them until they can come to us honestly and honorably and not in this treacherous way.

I would call the attenion of the readers of the REPORTER to a prize essay upon "Modern Homœopathy, its Absudities and Inconsistencies," by Dr. Browning, of Brooklyn, New York. It will abundantly repay any one who may wish to known about modern Homœopathy, to procure a copy of this essay.

Your Friend,
W. L. MARTIN.

Rancocas, N. J.

ANÆSTHETICS.

EDITOR OF THE MEDICAL AND SURGICAL REPORTER:—In your issue of May 27, 1893, p. 806, Dr. Gunterman in his article on "Chloroform" writes that Dr. Warren, also of Boston, "did the first surgical operation on a patient under the influence of ether. Sir Jas. Simpson, in 1847, was the first to use chloroform." I do not propose to open the question as to the discovery of modern anæsthesia; I have already treated of the subject in my book "Anæsthsia: Ancient and Modern," which had the honor of being reviewed in your journal of April 29, 1890. But I may draw your attention to the fact that, as I mention in my book, Dr. Long, of Jefferson, Georgia, in March 1842, etherized a patient from whom he painlessly removed a tumor. A very full and interesting account of this operation was published in the *Virginia Medical Monthly* for May, 1877, by Dr. J. Marion Sims, who had the account from Wilhite, of Anderson, S. C., who was an apprentice of Dr. Long and was present at the operation.

In 1831 Professor Ives, of New Haven, used a dilute chloroform—chloricether—as an anæsthetic and his case is reported in *Silliam's Journal* for January, 1832.

How ether came to be used by inhalation for the relief of pain, is told in an old and rare copy of *Beddoe's Journal* which, if time permits, I may some day publish.

Yours Truly
GEORGE FOY.

7 Cavendish Row,
Dublin, June 29, 1893.

It takes a fool a lifetime to find out what others see at a glance.

THE MEDICAL AND SURGICAL REPORTER

ISSUED EVERY SATURDAY

ADDRESS

Care P. O. Box 843, Philadelphia.

HAROLD H. KYNETT, A. M., M. D., Editor.

RODERIC C. PENFIELD, Publisher,

316-18-20 North Broad Street, PHILADELPHIA.

TERMS:—Five Dollars a year, strictly in advance, unless otherwise specifically agreed upon. Sent three months on trial for $1.00.

REMITTANCES should be made payable only to the Publisher, and when in sums of Five Dollars or less, should be made by Postal Note, Money Order or Registered Letter.

NOTICE TO CONTRIBUTORS:—We are always glad to receive articles of value to the profession, and when used they will be paid for, or reprints supplied, as the author may elect. Where reprints are desired, writers are requested to make a note of that fact on the first page of the MS. It is well for contributors to enclose stamps for postage, that the articles may be returned if not found available.

SATURDAY, AUGUST 5TH, 1893.

EDITORIAL.

PERITONITIS CAUSED BY THE PROTEUS VULGARIS.

Flexner (*Johns Hopkins Hospital Bulletin*, IV, 1893, p. 34) reports a case of peritonitis caused by the proteus vulgaris. The group of bacteria to which this species belongs was first studied by Hauser in 1885, who found the proteus group existing in decomposed albuminous substances. In pure cultures they were found to be able to induce putrefactive decomposition in meat, either sterilized or non-sterilized. There are a number of reported instances in which it appears that this group of bacteria may produce pathogenic changes in human beings. The case which Dr. Flexner reports is a marked example of this and important in bringing out the pathogenic effect of a bacillus usually considered of only saprophytic properties.

The case was in a young woman aged eighteen, white. She was admitted to the Johns Hopkins Hospital on October 29, 1892. When she entered she complained of pain in the abdomen. No history. She died October 31, two days after entering. The autopsy revealed chronic diffuse nephritis: sero-fibrinous peritonit is: acute pleuritis. "Peritoneal cavity—In its dependent portion, about 300c.c. of faintly turbid serum containing flakes of fibrin. The peritoneum congested, the vessels bright red and turgid, and small punctiform hemorrhages are visible beneath the peritoneal coat. Over the general visceral peritoneum there is a fine granular deposit of fibrin which, on removal, leaves the underlying coat of the intestine free from gloss and vividly injected." From the peritoneal exudate cover-glass preparations showed large bacilli only. No bacteria were found in similar preparations from the organs. Cultures were made from the exudate in the pelvis, fromt he peritoneum covering the diaphragm and from the liver, spleen, kidneys and lungs. The cultures from the liver and spleen remained sterile.

The cultures from the peritoneal exudate and kidney developed cultures of the proteus vulgaris. There was a slight

difference in the effect upon milk, but the author thinks them to be identical. Although the culture from the lungs developed coli bacteria, the author thinks that there can be little doubt that the proteus was the cause of the peritonitis.

"The proteus is a widely different organism in nature. It is found in the intestinal canal of human beings, and doubtless under ordinary conditions of health it might find its way into the peritoneal cavity without doing any great damage," but in the case cited the conditions were changed on account of chronic disease.

It is of special interest to know that organisms which do not exhibit under ordinary circumstances any special pathogenic properties in human beings, may, in the altered state of the fluids of the body caused by diseases, produce definite and widespread pathological lesions. Another foe is thus added to those against whom the abdominal surgeon has to contend. Under conditions usually existing, it is the pus-producing and the dirt-loving germs alone with which he has to deal, and with them strict asepsis, the free use of soap and hot water on the hands of the operator, combined with thorough irrigation and drainage of the peritoneal cavity, in those cases requiring it, would seem to be sufficient in most instances. Just how far the proteus vulgaris is accountable for peritonitis following seemingly clean operations remains to be seen, and we wait with interest further investigations of the subject.

OBITUARY.

CAMPBELL.—On July 14th, 1893, at the N.W. Cor. 10th and Wharton Streets, Philadelphia, J. Moore Campbell, M.D., in the 44th year of his age.

RESOLUTIONS of the Jefferson Medical College, Class of 1878, touching the death of Dr. J. Moore Campbell.

WHEREAS, In view of the loss we have sustained by the decease of our dear classmate and associate in the practice of medicine and of the still heavier loss sustained by those who were nearest and dearest to him, therefore, be it

Resolved, That we tenderly condole with the family of our deceased classmate in their hour of trial and affliction and commend them to the keeping of Him who looks with pitying eye upon the widowed and fatherless.

Resolved, That in our natural sorrow for the loss of our esteemed classmate, a faithful and eminent practitioner of medicine—believing the world is better he having lived in it—that we find consolation in the belief that it is well with him for whom we mourn.

Resolved, That this heartfelt testimonial of our sympathy and sorrow be forwarded to the family of our departed classmate by the President of the Jefferson Medical College, Class of 1878, and be printed in the Medical Journals of Philadelphia.

L. WEBSTER FOX, M. D., *President.*

H. A. BROUS, M. D.,
A. H. HULSHIZER, M. D.,
J. A. WAMSLEY, M. D., } *Committee.*

Hypodermic Injections of Iron in Anæmia.

Dr. Dantz, of Brussels (*La Semaine Medicale*), in two cases of very intense anæmia, in two working girls, has obtained rapid and considerable improvement from hypodermic injection of the following:

℞ Citrate of Iron.....gms. 2 (grs. xxx).
Distilled water.....gms. 30 (℥i).

Half a syringeful subcutaneously every two days.

Local Syphilides of the Scalp.

Dr. Rietema (*Deutsche Med. Wochenschr*), in local syphilides of the scalp, employes the following salve:

℞ White precipitate.....gms. 4 (℈j).
Corrosive sublimate.....gms. 0.2 (grs. iij).
Vasoline, Lanoline, } aa.....gms. 20 (℥v).
Oil of roses.....gtts. 5.

Wash the scalp with a solution of the bicarbonate of soda, and then rub in this salve.

ABSTRACTS.

TREATMENT OF LOSS OF SEXUAL POWER BY LIGATION OF VEINS.

The loss of sexual power, says Dr. Alfred King (*Boston Medical and Surgical Journal*), or rather deficient erections of the penis, render so many men miserable mentally and physically, that any new method of treatment, promising a radical cure, merits investigation and trial.

Three immediate causes of deficient erections may be specified: destruction of the erector muscles, loss of nerve power, and a change in the circulation. The first of these is so rare and so easily determined that it needs only a passing notice. The second cause, loss of nerve power, seems to me to have received more prominence than it deserves, as it is the basis on which almost all treatment is founded. While its force in many cases is undisputed, yet the frequent failure of treatment based upon it leads me to direct attention to the importance of the third cause, that is, a change in the circulation. This change takes place in the veins, especially those which do not pass beneath the pubic arch, or are not acted upon by the erector muscles. Repeated engorgement of the penis renders their calibre larger and, consequently, there is a more rapid escape of blood through them. When, therefore, an erection takes place, it cannot be maintained on account of the escape of blood through these channels. Thus we have the history of a gradual shortening of the duration of erections, and, finally, scarcely none if any, as these veins grow larger.

The remedy for such a condition, especially when far advanced, is not in the use of drugs, but may be brought about speedily and safely by the ligation of some of the larger of these veins.

The following case is given to illustrate this cause and its successful treatment:

Mr. M., aged thirty-five, a laborer of powerful physique, came to me about a year ago with the following history: For several years he had been losing the power of maintaining an erection, during the past year its duration having been so short that sexual intercourse had been rendered impossible. There was a loss of sexual desire and great mental depression. Excessive use or abuse was the cause of this condition.

I gave all possible encouragement to the patient; advised total abstinence from sexual intercourse, cold baths (especially to the spine and external genitals); prescribed bromides, cannabis indica, cantharides, damiana, phosphorus and salts containing it; pushed strychnine as far as it could be borne; gave various tonics; used electricity; and, in short, tried everything which offered any hope of success, but all to no effect so far as producing any stronger erections was concerned.

Careful study of the case convinced me that the immediate cause of the trouble was a physical one, due to a leakage, as it were, or to a too rapid escape of blood from the penis when erected. I, therefore, determined to ligate a couple of the larger subcutaneous veins at the base of the penis and watch the effect.

This was very easily done by the use of cocaine. A vein on each side of the penis was exposed, ligated in two places and severed between the ligatures. A dressing was lightly applied and held in position by a strip of adhesive plaster placed longitudinally. The result was immediate. In less than five minutes after leaving my office he had an erection. That night he was awakened by a powerful erection which made the bandage so painfully tight that he was obliged to jump out of bed onto the cold floor to subdue it. Primary union was prevented by the frequent erections, but the success of the operation was certain.

Two months later he reported himself well, mentally and physically; his sexual appetitite had returned, and since the operation, his power of maintaining erections had been as good as ever.

To Hasten Desquamation in Scarlatina.

The following is recommended:

℞ Resorcin ..... 3ij.
Lanolini ..... 3iss.
Olei sesami fl ..... 3ss.

Mt et. ft. ung.
Sig.—Rub into skin.

COCAINE IN GENERAL MEDICINE.

The following is a summary of the uses of cocaine in general practice, as elicited by the experience of Philadelphia physicians, collated by Dr. L. H. Adler and reported in the *International Medical Magazine*.

In several cases of chronic alcoholism cocaine did not appear to have any effect, or, if any, but an indifferent result in relieving the nervous depression and the craving for stimulants.

In the tickling cough of an acute angina cocaine acts promptly.

In two cases of asthma with moderate emphysema, a 2 per cent. solution applied to the Schneiderian membrane, promptly relieved the attack and seemed to delay its recurrence.

In chronic Bright's disease, complicated with typhoid fever and suppression of the urine, cocaine in ⅛ grain [8 mg.] doses (in addition to the digitalis and whisky previously employed) produced a copious secretion of urine within a few hours after its use. Good service has been had from cocaine in the anasarca from acute Bright's disease. In chronic Bright's disease (of both the parenchymatous and interstitial varieties) the drug causes a marked increase of the daily excretion of urine.

Cocaine is of no benefit in the cough due to bronchitis.

In cardiac dropsy, cocaine is of use as a diuretic, and especially is this noticeable in cases in which the pulse is feeble and the heart's action weak. In these cases, ¼ grain [16 mg.] doses, increasing to 1 grain [6 ctg.], were administered every 2 or 3 hours.

As a cardiac stimulant cocaine is not only usful but it is prompt and decided in its action. To this statement, however, we find several exceptions taken.

Dr. F. A Packard believes the drug to be useless as a heart stimulant, and Dr. Charles W. Dulles was disappointed in its employment for this purpose in a case of cardiac weakness associated with valvular insufficiency. Dr. James C. Wilson employed the drug a number of times in the latter stage of enteric fever, to combat the tendency to cardiac asthenia. For this purpose he administered it by the mouth and hypodermatically in doses of ¼ grain, [1 ctg.] repeated every 2-4 hours, or, where the effect was pronounced, at somewhat longer intervals. In a fair proportion of the cases, the drug appeared to have the properties of a cardiac stimulant; in other cases no obvious results followed its use; and in a limited number of cases its effect upon the circulation appeared to be distinctly depressant. Dr. Wilson believes the depression effects observed in certain cases to be due to idiosyncrasy.

In the vomiting of gastric catarrh, alcoholic or otherwise, cocaine ¼ – 1 grain [1.5–6 ctg.] doses, given alone or with bismuth, on an empty stomach, has given instant relief.

In acute nasal catarrh, cocaine, used in the form of a spray (10 per cent solution), has not only relieved but cured the catarrh.

As a cerebral restorative or excitant, the coca-leaf, in the form of a reliable extract, alcoholic or aqueous, is to be preferred to the alkaloid. The fluid extract of the coca-leaf seems to contain other principles and to differ from cocaine in its action almost as opium differs from morphine or cinchona from quinine. Dr. James H. Lloyd believes cocaine to be very potent as a brain stimulant, but he thinks that its use as such is apt to do more harm than good.

As a temperature-elevator in cases of general collapse, cocaine is useful.

The concensus of opinion seems to be opposed to the use of cocaine in the nares unless extreme care be observed and the patient be kept in ignorance as to the remedy employed. In two cases of coryza, in which the drug was used, toxic symptoms ensued. The strength of the solution used in one case was only 2 per cent.

In chronic cystitis, cocaine will afford temporary relief when injected into the bladder, but it must be used with care and caution.

Cocaine has been used in cases of debility of old age. In combination with strychnine and quinine, in doses of ⅛ grain [8 mg.], it has been found to be a safe and good tonic. Dr. J. Cheston Morris does not think it equal in these cases to the elixir of ammonium valerianate.

In the dropsy of both renal and cardiac origin, the internal use of cocaine, in solution or pill form, has proved a useful diuretic when given in doses of ⅛-¼ grain

[8-16 mg.] every 2 hours. Even in cases of complete suppression of urine, which was not relieved by the use of digitalis and whisky alone, cocaine, given in the manner and dose mentioned, soon caused the urine to be secreted.

Cocaine, in the form of a suppository, has been used with some advantage in relieving the tenesmus of dysenteric disorders, especially in the entero-colitis of children.

Good results have sometimes followed the use of cocaine in the several varieties of dyspepsia. The dose employed has been ¼–1 grain [1.5–6 ctg.], repeated several times a day. Dr. S. M. Wilson states that in cases of dyspepsia where much general weakness was complained of, the administration of cocaine gave temporary relief only; later on the stomach-trouble seemed to be aggravated.

Sometimes a single dose of cocaine will stop the nausea and retching following ether-anæsthesia. In other cases ¼ grain doses [1.5 ctg.] will have to be given hourly.

Wine of coca has been found superior to other remedies in relieving the suffering from hectic fever.

Cocaine has been found of service as a general stimulant in cases of exhaustion occurring during the course of prolonged diseases, such as typhoid fever, particularly when collapse was threatening. In febrile conditions accompanied by irritability of the stomach, the use of the drug, ten or fifteen minutes before giving food, will enable nourishment to be retained when otherwise it would be rejected. To combat the tendency to cardiac asthenia occurring in the later stages of enteric fever, cocaine may be given by the mouth or hypodermatically in doses of ⅛ grain [1 ctg.] every 2 or 4 hours. In the tremor following typhoid fever, cocaine in some cases seems of permament benefit, and in others its effects are only transitory.

Cocaine is useful in many cases of vomiting dependent upon gastric irritability. It is advisable, in cases of violent nausea and emesis attendant upon gastric irritation from the ingestion of faulty articles of diet, etc., to precede the administration of the cocaine by lavage, in order to get rid of the irritants before applying the sedative. In cases of sympathetic vomiting this preliminary cleansing of the stomach is not necessary. The dose of the drug is $\frac{1}{16}$-¼ grain [4–16 mg.] in one or two teaspoonfuls of water.

Gastritis.—Excellent results have been obtained from the use of cocaine in those cases of gastritis in which the drug could exert a direct local effect.

In cases of gastrodynia, cocaine in ¼–1 grain [1.5-6 ctg.] doses, given alone or in combination with bismuth, on an empty stomach, has given instant relief.

In hay-fever, where there is often a markedly neurotic element, Dr. J. H. Lloyd believes that the relief obtained from the use of cocaine is often followed by a reaction which leaves the patient distinctly worse. This gentleman states that he has never known its use to cure this disease. In the asthma of hay-fever, Dr. James M. Anders has found of service a 2 per cent solution of the drug applied to the nares.

As a brain-stimulant, cocaine should not be employed in hysteria, both because its relief is slight and temporary, and especially, because of the danger of forming the cocaine-habit.

In two cases of impotence, wine of coca was given a full trial, but without obtaining any result.

Cocaine has been beneficial in hyperæsthesia of the larynx and pharynx when unaccompanied by any structural lesion in them or in any other organ. The drug should be given in doses of from $\frac{1}{16}$–$\frac{1}{10}$ grain every 4 hours.

Cocaine has been used in melancholia with negative results, except in the acute forms of melancholia agitata, when its employment seemed to give ease to the patient.

Cocaine has been used to combat the opium-habit; the plan of treatment being a descending dose of opium, and an ascending dose of cocaine. The limited experience had with it in these cases is rather unfavorable to its employment.

Cocaine as a spray to the throat and larynx in the sore-throat of advanced phthisis is a temporary relief. Its action, however, is very fugacious, and the patient is apt to want it constantly. Combined with cubebs and morphine, in the form of troche, cocaine in $\frac{1}{10}$ grain [3 mg.] dose, has relieved the cough of phthisis. In the distressing vomiting so often seen accompanying pulmonary phthisis, which is due to the cough, cocaine has been given, but not with satisfactory results.

For the vomiting of pregnancy cocaine occasionally gives relief, but more often it fails. It is probably in the neurasthenic class of these cases, as pointed out by Dr. William L. Taylor, that cocaine is useful. It should be given by the mouth in doses of $\frac{1}{10}$-$\frac{1}{4}$ grain [6-15 mg.] every 2 or 3 hours. It may be advantageously combined with monobromated camphor (1 grain [6 ctg.]) or zinc phosphide ($\frac{1}{10}$ grain [6 mg.]).

Cocaine given by the mouth in doses of $\frac{1}{8}$ grain [8 mg.] has been successful in relieving severe pyrosis.

In cases of œsophageal stricture, cocaine has been used with benefit for two purposes: to allow of the painless passage of the œsophageal bougie, and to enable the patient to eat with comfort by relieving the additional spasmodic constriction which is produced by the contact of food with the mucous membrane of the œsophagus.

Results obtained from the use of cocaine as a general tonic have varied, being favorable and otherwise. When employed for this purpose, cocoa should be given in the form of the wine or in the form of a reliable fluid extract, alcoholic or aqueous.

Indifferent effects have been noted as a result of the use of cocaine in tremor following typhoid fever.

In the pain and vomiting of gastric ulcer cocaine in $\frac{1}{4}$-1 grain [1. 5-6 ctg.] doses has proved very effective. Its administration has also enabled the patient to eat and retain an increased amount of nutriment.

A METHOD OF TREATING COMPOUND FRACTURES.

The method aims at being simple, and in the following account it may be considered as applied to the commonest of compound fractures, viz., those of the leg. On admission, the limb is covered with lint soaked in carbolic lotion and is subsequently cleaned with the greatest care; protruding bone is replaced, loose or damaged bone is removed, and the broken ends are adjusted by means of splints with as little delay as possible.

1. Ordinary well-padded wooden splints are employed, but under no circumstances is the limb secured to the splint by means of strapping. Strapping may be used to form a stirrup whereby extension may be applied in the fractures of the femur or humerus, but no other forms of plaster appears to be other than objectionable when the question of fixing the limb is concerned. If the strapping be adjusted with sufficient firmness, it will often be found that within twenty-four hours the limb has swollen and the strips of plaster are cutting into the soft parts and are impeding the circulation. The strapping then has to be cut or reapplied, and a second adjustment of the limb is rendered necessary. On the other hand, in process of time, the band of strapping is found to have come loose from shrinking of the limb, and a further readjustment of the fractured parts is called for. In the place of plaster, straps of fine webbing and buckles are made use of to secure the limb to the splint. These vary in length, and are applicable to all parts. If found to be too tight or too loose, they can be altered as often as necessary in the day without the least disturbance of the limb. In this way the limb can be secured with a proper degree of firmness. Where the webbing crosses the shin or the dorsum of the foot, a small shield made of gutta-percha, and lined with lint, is interposed. When side splints are employed, these also are held in place by straps and buckles. No bandages are ever applied. They are quite unnecessary. They cannot be readily tightened or loosened, and they cover up to an undesirable extent the damaged parts.

2. In the second place, the limb is kept throughout in the open air. This would happen by necessity, more or less, in the case of the upper limb, but it is insisted upon also in all fractures of the lower limb in which there is a wound. If the principles of aseptic surgery be well founded, a worse atmosphere with which to surround a wound could scarcely be found than that which exists under the bedclothes. This atmosphere is confined, is hot and moist, and when flatus is passed or the bed-pan is used must of necessity become especially offensive. In all compound fractures of the leg or thigh, the limb is kept throughout entirely uncovered

as well by night as by day and in the winter as in the summer. In cold weather. the nurse makes a cotton-wool cap for the foot, but during the six years in which this rule of uncovering the limb has been observed there have been no complaints of chill or evils arising from exposure. It might be mentioned that in the author's wards in all cases of wounds of the lower limb, including amputation wounds, and in all cases of ulcer, the part is kept throughout the whole period of treatment uncovered save by the necessary dressings, and since this plan has been adopted the results have been infinitely improved.

3. The third element in the treatment concerns the treatment of the wound. In cases of compound fracture there is usually a not inconsiderable amount of bleeding and oozing from the wound which will often be continued for many days. It is very desirable that this fluid should not be pent up in the limb, and that it should be allowed the freest possible means of escape. The plan of lealing the wound with collodion may be spoken of in general terms as bad. It can in no way control the oozing, which may long continue from the damaged parts, and merely confines within the recesses of the limb a fluid which is admirably adapted for the development of bacteria.

While a free exit should be given for all discharges of blood and serum, such a barrier must, at the same time, be erected as will prevent the entrance of pus-producing bacteria. A dressing of antiseptic gauze wool may possibly meet these conditions, but in a large proportion of cases isucha dressing needs to be very frequently changed, and such a change cannot always be effected without disturbing the position of the broken bones and putting the patient to no little inconvenience.

In the present collection of cases, the wounds have been simply covered with a heap of dry antiseptic powder, which has been applied without stint. This covering of powder may be considered to seal the wound, so far as the possible entrance of bacteria is concerned, while at the same time it in no way impedes the free escape of blood and serum from the damaged parts.

The discharge finds its way into the protecting powder, and forms with it a harmless scab or crust. As the powder becomes saturated, more and more of it is applied, but the crust produced is not disturbed. In certain cases the oozing continues for many days, and in one or two instances the crust produced has exceeded the size of the adult fist. The powder employed has been iodoform or creolin. The latter has been found to be the more convenient. For the first few days the powder may need to be dusted on every few hours, and as the limb is kept always uncovered the saturation of the crust can be at once noticed. When no more blood is found to be escaping the powder is discontinued, and some seven days after this period the artificial scab is removed and the wound beneath may be expected to be healed or to be healing.

When the laceration occurs upon the upper surface of the limb there is no difficulty in covering it with powder. When it is placed upon the sides of the extremity a platform of cotton wool must be so fixed in place that the powder, when dusted upon it, will bury the wound. The cotton wool may be kept in position by fixing it in position against the side of splints, or by attaching it to the skin by gum.

The following advantages may be claimed for this method: It is simple, and requires but the simplest appliances. The fracture, when once adjusted, need not be again disturbed. The damaged part is kept exposed to view, and the position of the ends of the bone can be ascertained at any time.—Frederick Treves, F. R. C. S., in *Annals of Surgery*.

Acute Rheumatism.

Le Progres Medicale gives the following:

1. ℞ Tinct. aconite.....gms. 12 (℥iij)
Destill. extr. hamamelis.....gms. 90 (℥iij).
Alcohol.....gms. 60 (℥ij).

Liniment. Apply locally and cover the joint with a flannel.

2. ℞ Phosphate of Iron.....gms. 0.3 (grs. v).
Bromide of lithia.....gms. 25 (℥v).
Distilled water.....gms. 120 (℥iv).

A teaspoonful every two or three hours, in water.

3. ℞ Salicylic acid, Bicarbonate of soda, } aa.....gms. 8 (℥ij).

Sufficient for twelve powders. One every two or three hours.

For Shock Following Abdominal Operations.

Dr. E. P. Davis gives the following in cases of slight shock following abdominal operations:

℞ Elixir ammonii valerianati.....℥j.
Spirit frumenti.....℥ij.
Aqua bullient.....℥ij.

M. Sig.—As an enema every two hours.

WHEN AND WHY THE BABY SHOULD HAVE A DRINK OF WATER.

CHARLES G. KERLEY, M. D.

Does the thought of giving the baby, whether sick or well, a drink of water ever occur to the mother of a nursing or bottle-fed infant? This question can be answered, with but few exceptions, in the negative. Does it occur to the physician to suggest the same for his little patient? Comparatively seldom. The idea that an infant should not have plain water to drink is so thoroughly grounded in the minds of many people that they rebel when it is suggested to them. In an experience with several hundred mothers of young babies, both in institutions and in private life, I have met with but very few to whom the idea had ever suggested itself. The opinion seems to prevail among the better class that a babe less than one year of age should get nothing but milk or some one or more of the liquid foods. A great many of my dispensary patients are given everything drinkable but water.

Every physician who has much to do with children has often elicited the following history of his patient after a careful inquiry: The bottle-fed infant was taken sick with some slight ailment accompanied by fever; perhaps there was a slight bronchitis, or a tonsilitis, or a dyspeptic catarrh; at all events the child was feverish and thirsty; the usual amount of milk, at other times sufficient, now did not satisfy; the baby cried for the bottle after feeding, and was only appeased by an extra allowance of milk. This indulgence was continued for a day or two, and was followed by diarrhœa and vomiting, directly produced by the repeated overloading of the stomach, the severity of the attack varying according to the condition of the child, the season of the year, the nature of the food given and the surroundings. The crying for the bottle was interpreted by the mother as a call for more food, and as the crying was stopped when it was given, the process was repeated. The babe did not require more food; it was thirsty and would have been just as well satisfied with a tablespoonful or two of water, and the unpleasant, if not dangerous, results of overfeeding would have been obviated.

So thoroughly have I become convinced of the great benefit derived from giving water to sick babies that I now order it in nearly every case with fever, and it is astonishing to see how the restlessness and many of the symptoms we are apt to attribute to pain and fever disappear when it is given freely. By freely I mean from ½ to 2 ounces immediately after or between the feedings. If given immediately after the feeding a smaller quantity will, of course, be required. Time and again I have seen infants with measles, scarlet fever or pneumonia, after a period of great restlessness, fall into a quiet sleep when a couple of ounces of cool water had been given.

In summer diarrhœa, the so-called cholera infantum, with the large watery evacuation, the loss of fluids from the body is enormous. In such cases, the little patients take the water ravenously. I have given babies eight to twelve months old, with severe diarrhœa, from 4 to 6 ounces of water every two hours, alternating with the sick diet, which was also a fluid. Sometimes after taking such a large amount the child will vomit, especially if it is handled a great deal. The patient should, therefore, be kept absolutely quiet; but if vomiting occurs it can do no harm; in fact, it may be beneficial, as it serves to wash out the stomach, possibly removing curds and offending material, and so taking the place of a stomach washing. After a few minutes of rest a couple of tablespoonfuls may be given, and will almost always be retained.

In some forms of illness it is necessary to diminish the amount of food given. In these the loss in bulk should always be substituted with water. During the hot months of July and August the breast-fed infant is apt to be nursed too frequently or too long at a time, consequently overnursed—more milk is taken than is required. If a few teaspoonfuls of water are given after it has nursed the proper time, the babe will be just as well satisfied. Or if too frequent nursing is the trouble, a small amount given between the regular nursing hours will enable the child to go the usual time without inconvenience. If this is done, the babe will not be overfed; and, further, the water, if given immediately after the nursing, will assist in

the digestion of the milk by causing the curd to form in smaller masses, and it is, consequently, much more easily acted upon by the stomach juices, thereby helping to keep the stomach in a healthy condition, the chances for serious trouble being thus largely lessened. If a drink or two is given at night during the excessively hot weather, it will help to break up the pernicious habit of frequent night nursing, produce sleep and comfort for the child and much-needed rest for the mother.

The water to be given should be boiled, put in a cool place and kept carefully covered. It should never be given very cold. It will usually be well taken from an ordinary nursing bottle at a temperature of 50° to 70° F. Some babies will not take the water at all, at first, if it is cool; in such cases, of course, it can be warmed. It will readily be seen that the advisability of giving the baby water to drink when indicated as above is unquestionable. Harm it cannot do.—*Mother's Nursery Guide.*

THE INFLUENCE OF DISEASE OF THE EAR UPON THE DEVELOPMENT AND COURSE OF INSANITY.

The following is an extract by Ireland (*Journal Mental Science*), from a resume of Dr. Bjeljaknow (*Boston Med. and Surg. Journal*), who has studied the subject in a hospital of St. Petersburg. He has confined his observations to cases where there was distinct inflammation of the middle ear.

Out of the post-mortem examinations which he made during four years, 17.12 per cent. suffered from internal otitis. Of these, one of the patients had melancholia, one paronoia hallucinatoria acuta, eight paranoia hallcinatoria chronica, two secondary dementia, three epileptic insanity, four general paralysis, one acute delirium, one senile dementia and three hebephrenia.

The author, at the end of his paper, gives the following conclusions:

1. An inflammatory process of the internal ear is frequently the cause of mental derangement, especially of insanity accompanied by hallucinations.

2. If the local inflammatory process takes an unfavorable course, the insanity often passes into secondary dementia, which, otherwise, this form of insanity is not so liable to do.

One-sided hallucinations of hearing are very frequently the result of a heightened excitability of the cortical centers, the result of the transmission of the irritation from the auditory nerves.

3. Hallucinations of hearing on both sides, which support the hypothesis of the independent function of each hemisphere, may be caused through disease of the auditory apparatus.

4. Irritation of the organ of hearing frequently does not stop at exciting hallucinations of hearing, but as a result of the influence of this sense upon the other, it also excites other hallucinations, especially those of taste, smell and general sensibility.

The character of the delusions of the sense is tinged by the personality of the patient.

5. In many of these patients who suffered from ear disease, there was found a hyperesthesia of hearing which, as a sequel to noises or musical sounds in the ear, becomes changed into a diseased sensation.

At the same time, the sensibility to hearing outward sounds is not increased, but, for the most part, diminished.

6. The overflow of saliva, which often accompanies suppuration of the middle ear, is caused by irritation of the chord and the nerves of the tympanic plexus.

The hypochondriac depression and pain about the pericardium, which from time to time trouble these patients, may be explained through irritation of the nervi-vagi of the auricular branch and the propagation of this irritation to the auditory brain centers.

7. The connection of disease of the ear with insanity accompanied by hallucinations is only observed in cases where mental activity and apprehension are not yet much diminished.

8. Epilepsy seems sometimes to depend upon disease of the labyrinth.

The irritation, coming from inflammation of the middle ear, may assume the form of a false general paralysis.

9. Hallucinations of hearing, though rare in general paralysis, may, when they appear, be the result of otitis on one side. In this case the hallucination is generally confined to the same side of the brain.

SELECTED FORMULÆ.

Cutaneous Diseases.

Nothing is better, says A. T. Thompson, to allay itching in cutaneous diseases than the following:

℞
Plumbi acetatis.....grs. xvj.
Acidi hydrocyanici diluti.....ʒjss.
Spiritus rectificati.....ʒiv.
Aquæ destillatæ.....ʒvijss.

M. Sig.—Fiat lotio.

Prevention of Boils.

Dr. Rosenbach (*Munch. Med. Wochenschr.* No. 8, 1893), in order to prevent the development of crops of boils, in the back of the neck and nose, especially advises persistently rubbing the region attacked with some fatty substance, as cold cream, *lanoline*, unsalted butter or lard. Lanoline, above all is to be preferred. The development of boils is due to dryness of the skin, and by inunction of a fatty substance the dryness is removed and the penetration of micro-organisms prevented.

For Chronic Bronchitis and Emphysema.

The following is recommended:

℞
Ammonii carbonatis.....grs. iv.
Tincturæ scillæ.....mxx.
Spiritus ætheris.....mx.
Tincturæ nucis vomicæ..... mx.
Infusum serpentariæ ad.....ʒj.

Misce et fiat mistura.
Two tablespoonfuls every six hours.

PROF. GRAHAM ordered the following as a dusting powder for syphilitic eruptions on a child.

℞
Acid boraric..... ʒ ij
Hydrarg chlorid mitis ..... ʒ ij
Lycopodii ..... ʒ vj

M. Sig. Dust on the parts affected night and morning

Atrophic Rhinitis.

℞
Thymol ..... grs. jss.
Alcohol, } .....ää ʒjss
Glycerini, }
Aq. dest ..... ʒj

Use as a spray.

Zinc Glue.

Trentler recommends a preparation, first suggested by Una, for stiff surgical dressings suitable for fractures and dislocations:

℞
Oxide of zinc ..... 10 parts.
Gelatine..... 30 parts.
Glycerine ..... 30 parts.
Water ..... 30 parts.

Apply thickly, rubbing into the muslin or gauze forming the bandage.

—*Ex.*

Enlarged Tonsils.

Dr. Moure cauterizes with this:

℞
Trichloracetic acid.....gr. i ss.
Iodine .....gtts. iv.
Iodide potash.....grs. viij.
Glycerin.....fʒii¼.
Distilled water.....fʒiiss.

Nocturnal Sweats of Consumption.

Dr. Ewart (*La Sem. Med.*) speaks highly of the following pill, in the night-sweats of consumptives:

℞
Sulphate of quinine, } aa. gms. 1.5 (grs. xxij.)
Sulphate of zinc, }
Ext. of hyoscyamus, }
Ext. of nux vomica....gms. 0.5 (grs. vijss.)

Make sufficient for twenty pills. Two pills on retiring.

Herpes Zoster.

Broca recommends the following in herpes zoster:

℞
Acid. boric.....ʒss.
Zinci oxid., } aa.....ʒj
Pulv. amyli, }
Vaselin., pur.....ʒiij.
Lanolin.....ʒivss.

M. Ft. unguent.

Aqua Picis in Cholera.

Polubinski has observed in choleratic patients real benefit from the use of tar-water, which he gave internally, in small quantities, in form of clysters. It many times arrested violent diarrhœa and vomiting, and improved the *bien-etre* of the patients.—*Trans. Omsk Med. Soc.*, Vol. ix, No. 9.

Bites of Insects.

Dr. E. Lang (*La Sem. Med.*) praises the following preparation in the bites of insects:

℞
Liquid ammonia.....gms. 3 (gtts. xlv.)
Collodion.....gms. 1 (gtts. xv.)
Salicylic acid.....gms. 0.1 (grs. jss.)

Apply a drop upon each bite.

—*Pritchard.*

Constitutional Syphilis.

A mixture often ordered by Dr. Keyes is as follows:

℞
Potass. iodid..... .....ʒij
Ammonii carbonatis.....ʒss.
Tr. cinchonæ comp.....ʒiv.
Syr. aurantii cort.....ʒjss.
Glycerinæ.....ʒj.

M. Sig.—A teaspoonful, well diluted, after each meal.

CURRENT LITERATURE REVIEWED.

THE CHICAGO MEDICAL RECORDER

for July. Dr. Archibald Church contributes an article on

The Removal of Ovaries and Tubes in the Insane and Neurotic,

in whch he comes to the following conclu sions:

1. The removal of the adnexa is not justifiable in cases of pure functional neurosis. 2. Even when appreciable disease of the tubes and ovaries is present, an operation should not be performed until palliative treatment has first been tried. The results in hystero-epilepsy and hystero-mania are so uncertain that celiotomy is not to be advised.

Dr. Edward Wyllys Andrews discusses

An Improved Operation for Varicocele.

The operation is described as follows:

The redundant scrotal skin is grasped as in preparing to apply the clamp. Having crowded the testes upward until there appears but little more room for them, and it is apparent that the skin over them is reasonably tense, the part below this is marked for removal with all such veins pertaining to the varicocele as can be taken up with it. Now, intead of the clamp, a line of sutures is made to separate the portion to be removed from that above, the line being carried from the perineum forward in a curve to some point below the bulb of the penis.

If quilled sutures are inserted they should be placed one-half an inch apart and drawn not too tightly.

The plan the author prefers is to thread two silkworm guts upon straight needles and tie the other ends to each other, thus getting a long piece with a needle at each end. Beginning at the perineal end, the double stitch is now carried forward in loops of one-half or five-eighths of an inch in length, the needles inserted being from opposite sides and crossing each other each time until the front is reached, where the free ends are tied to each other.

One reason for preference for this form of deep suture is because it shortens the line as well as compresses laterally by a sort of puckering string action.

Having secured contact of the two sides of the scrotum by this permanent substitue for the clamp, it only remains to divide the skin, and contained varices, about half an inch below this line and secure all bleeding which the compression of the deep sutures may permit, after which a continuous horsehair or other superficial suture will complete the operation.

The author states that his success with this operation has been perfect. Union of the superficial wound usually takes place in five or six days, but the author prefers to leave everything untouched for about fourteen days, removing everything at that time, including the retention sutures, and sealing with collodion any small unhealed spot.

The operation should be done with rather minute care, especially in the final step of approximating the scrotal skin which is thin and needs careful suturing with a fine needle and very numerous small stitches to insure nice closure. It is well to use a few horse-hair drains of a dozen or two fibres each, to remove the excessive serum by capillarity and prevent local distension.

Dr. A. E. Hoadley reports "Six Cases of Metatarsalgia." In one case the pain was relieved only by the resection of a small neuroma on the digital branches of the plantar nerve. The other cases recovered by the use of a properly fitting shoe provided with a stiff sole to prevent bending of the foot.

Mr. Ernest Hart, of London, contributes a most able article on "The Health Conditions of Chicago." With his characteristic clearness, he points out the great danger from the water supply and the constant danger of its polution by sewerage from the Chicago River. He also shows that the typhoid mortality of Chicago is above that of any great city of the world. He urges that the cribs for the intake of the water supply be all moved out four miles into the lake and that a system of subsidence and filtration be established.

The remaining papers in this month's issue are: "Electro-diagnosis" by Dr. Edwin R. Bennett; and "A Case of Carcinoma of the Tongue" by Dr. Bayard Holmes. The growth extended, after two partial extirpations, to the alveolus. Partial excision of the lower jaw and partial excision of the tongue was performed with the result that no recurrence has taken place in three and one-half years.

THE CANADIAN PRACTITIONER

for July. Dr. R. W. Powell contributes an article on

The Management of Abortion.

When an abortion threatens, complete rest in bed on the back must be enjoined, and avoidance of all excitement; plain, easily-digested food allowed. Opium is to be given in full doses, and repeated sufficiently often to keep up its effect. Solid opium, morphia by the mouth or hypodermically, laudanum per rectum or in mixture, and also suppositories, may be used in such a case, at the discretion of the practitioner. Viburnum also has been highly lauded; pot. bromide is often very useful. These measures frequently avail to stave off the abortion, and if they do we should insist on the patient remaining in bed a week at least after the symptoms have entirely disappeared, and to resume her ordinary mode of life and avocations gradually, and with care to avoid all those causes which tend to a recurrence of the symptoms.

When the patient is actually aborting, he advocates the "let alone" policy, especially in primipara in whom the hemorrhage

is less likely to be excessive. If the pains are regular and good, nothing is demanded except rest in bed. He does not favor even vaginal douches in such a case, unless the local discharge is offensive, in which case he prefers a weak solution of permanganate of potash in boiled water and a pad of sublimate jute to receive the discharges. If the pains are not good he advocates a dose of ergot.

In cases where the hemorrhage is excessive, and is coming away in clots, and especially where the patient is a multipara, the vaginal tampon, properly applied and tucked well around the cervix, is a useful means of assisting the process of dilatation. It likewise, by preventing the continuance of hemorrhage, allays the patient's fears. When the amniotic sac ruptures and the ovum is discharged minus the decidua, the hemorrhage is apt to be severe; to control this, he advocates the use of gallic acid and ergot, combined with a little opium or chloroform if the pains are severe and hard to bear. He has found the tampon useful in these cases in limiting the hemorrhage and promoting the dilatation of the cervix. The tampon should be changed every four to six hours according to the severity of the pains and the amount of hemorrhage. When the decidua is not discharged it must be removed and for this purpose the author prefers the index finger used as a curette. He does not advocate the immediate washing out of the uterus after an abortion. An offensive discharge, a chill and rise of temperature following an abortion would indicate that an intra-uterine douche was demanded. For this, the author prefers carbolic acid and permanganate of potash.

W. Lehmann, M. B. contributes a translation of an article on

Lithopædion,

by Dr. Gottschalk, of Berlin. Thirty years ago the patient had an extra-uterine pregnancy, the case being left to nature. Two years ago the mass slipped down into the pelvis and the patient suffered from pressure symptoms and became so emaciated that a section and removal of the mass was finally advised. The appendages of the right side were perfectly normal but the left ovary was entirely absent, the whole ovum lying in an ovarian sac. The author therefore believes that the case was originally one of ovarian pregnancy. The patient recovered perfectly.

PERISCOPE.

THERAPEUTICS.

Caffeine-Chloral.

Chloral possesses the characteristic property of all aldehydes to combine with a variety of chemical substances, especially with those of a weak basic character, such as formamide, urea, cyanogen, etc., in which the physiological action of the respective compounds are more or less modified. The therapeutical advantages of some of these combinations are illustrated in the use of chloralamid, the compound of chloral with formamide, and it appears that a similar combination of chloral with caffeine may prove a valuable remedy in cases of constipation and in irritable conditions of the peripheric nervous system.

Caffeine-chloral has been recently employed with success by Ewald, who administered it subcutaneously dissolved in water, in single doses of three to five grains up to six to fourteen grains pro die. The injections were generally unaccompanied by the slightest pain, although individual patients complained of a slight burning sensation at the point of injection, which continued for about three hours.

Thirteen cases of constipation were treated: thin stools passed within three hours of injection of three to six grains caffeine-chloral in all cases in which the constipation was of three to six days' duration. In one instance an ounce of castor oil had been administered the day before without effect and copious irrigation had also been unsuccessful. Constipation appeared again in this case five days later, and six grains effeine-cahloral were administered at intervals of two hours without previous dosage with castor oil, with like success.

In one case of gastric ectasis accompanied by severe paroxysms of pain in the neighborhood of the stomach, 5 grains caffeine-chloral were administered to combat the pain. The patient volunteered the information next morning that a thin stool passed a few hours after the injection and since that time the stools have been well formed and regular. Only one out of the thirteen cases of constipation withstood the remedy, and here irrigation had to be again resorted to.

Ewald also administered caffeine-chloral in eight cases of rheumatic difficulties, and in seven cases the pain and swelling of the joints was mitigated by injections of three to six grains pro die. In all these cases previous treatment with sodium salicylate for periods varying from two to seventeen days had been without effect upon the course of the complaint.

A complete disappearane of pain is reported in one case of ischia after a few days' treatment with injections of 3 grains daily, and considerable improvement was noticed in a case of supposed rheumatic pains in the testicles and hip-joints. The injections also proved serviceable in reducing the pain after lead poisoning.

In two cases of emphysia accompanied by violent attacks of asthma, which resisted

morphia, the rapid disappearance of complications after a single injection of three grains caffeine-chloral was remarkable. The asthmatic difficulties in a case of nephritis and myocarditis, were also diminished by injections, which further exerted a favorable influence on the chronic constipation.

As a result of his observations, Ewald is therefore in a position to state that the injections of caffeine-chloral have, besides a loosening action in cases of constipation, also a quieting and soothing influence upon the peripheric nervous system in irritable conditions. To what extent this action is due to the caffeine is at present doubtful, as experiments on animals have indicated that in the presence of the influence of chloral, the action of caffeine in less than toxic doses, is almost completely masked. It is also a well-known experience that in similar combinations of chloral with other bodies, such as urea and cyanogen, the specific action of the latter is almost completely annulled. Ewald therefore refrains from expressing a definite opinion as to the specific action of caffeine-chloral until further experiments have been made.

Losophan.

Felix Descottes formulates the following conclusions: In the treatment of leg ulcers losophan acted quite as well as any of the medicaments employed in this condition. In primary lesions of a syphilitic character losophan had a very beneficial action and determined a rapid cicatrization of chancre though employed to the exclusion of the general constitutional treatment. The curative effects of losophan were especially manifested in simple chancre or soft chancre. Patients suffering from folliculitus and eczema, although not always completely cured under treatment by losophan, experienced in all cases a great amelioration of condition. In circumscribed lichen simplex losophan successfully cured the disagreeable and sometimes very painful pruritus which almost always accompanied this malady. In prurigo with obstinate pruritus the same beneficient result was obtained. Descottes employed losophan in much stronger mixtures than cited by other authors and never noted any irritation of the skin. He used eight per cent., ten per cent., and sometimes twenty per cent, ointments and solutions, and was successful in some conditions which had not heretofore responded promptly to losophan.

Indications for the Administration of Chloralamid.

Dr. J. Hobart Egbert says: Having kept a record of more than one hundred cases in which chloralamid was administered for hypnotic and soporific effects with uniformly gratifying results, I believe that a review of some important indications for the exhibition of this remedy, as shown in these cases, will prove of practical value.

In preparing patients for operations, of even more importance than the orthodox laxative is the securing of refreshing sleep and, if possible, tranquillity of mind and freedom from depression. Nothing so prepares the human frame for the knife of the surgeon as deep, natural sleep on the eve of the operation. How, then, may this desideratum be secured? Opiates are at once excluded by the subsequent depression and digestive disturbances which they occasion, and many of the modern hypnotics are likewise barred on occount of their marked after-effects. With a view to obtaining calm, refreshing sleep prior to operations (and especially in operations upon the eye when no anæsthetic is employed), and otherwise preparing the minds of patients for the ordeal, we have latterly administered full doses of chloralamid at bed time for two or three nights before the operation. The results have been uniformly gratifying, not only in obviating much restlessness and discomposure at the time of operating, but also in securing immunity from surgical shock—symptoms of which are not infrequently observed after even trifling operations.

After every successful operation there comes a relaxation of the mental tension which has quietly, but firmly sustained the patient during the ordeal. This relaxation is naturally attended by a disturbance of nervous equilibrium, and as a result, unrest and insomnia are apt to ensue. When, in this event, insomnia is not dependent upon absolute physical pain, chloralamid is strongly indicated—not only because of its valuable sleep-producing qualities, but in virtue of its tonic action on central nervous cells and fibres, and *its power to relieve intra-cranial congestion.* This last-mentioned quality of chloralamid renders it an agent of superior value for post-operative administration in ophthalmic surgery. In these conditions we ordinarily prescribe chloralamid in extemporary elixir, using as a menstrum the Elixir Simplex of the U. S. Pharmacopœia.

Restlessness, insomnia and coma vigil are serious symptoms common to typhoid fever, and are indications for the exhibition of chloralamid. Since, in this disease, they are attended with much debility the remedy is best administered in brandy and water.

In the insomnia or fatiguing sleep of that debility of the nervous system commonly spoken of as nervous prostration or spinal irritation, and in all cases of nocturnal restlessness caused by excessive mental exertion or emotion, chloralamid has a wide field of usefulness and is early indicated. This drug is not contra-indicated by attendant debility; nor is its prolonged use likely to occasion either functional or organic disturbances, nor lessen its power to relieve.

Chorea is an indication for chloralamid. Not only should it be administered when muscular movements interfere with sleep, but systematically as curative of the disease. In the treatment of this affection it will sometimes be found advantageous to combine hyoscyamus with the chloralamid. Here is an eligible formula:

℞ Chloralamid..... ℥ss
In spts. vini gallici ℥i solve, tum adde
Tinct. hyoscyami..... ℥iv
Tinct. valerianae..... ℥i
Elixir simp..... q. s. ad ℥vi

M. Sig.: A teaspoonful four times a day.

In my own observation, attacks of chorea which have resisted morphia, have promptly yielded to ten grain doses of chloralamid.

In the insomia or disturbed sleep with unpleasant dreams which result from alcoholic, tobacco, and sexual excesses, chloralamid has a special field of usefulness. It should be given in full doses at bed-time, while mineral tonic and reconstructives should be administered throughout the day, and such a course, if accompanied by proper abstinence, will relieve the overtaxed economy, and prevent the otherwise inevitable spinal and cerebo-spinal sequelæ.

In mania and melancholia, chloralamid is superior to chloral and the bromides, not only for securing sleep but in contributing materially towards recovery—it being now a general opinion that cases of *acute* mania treated by these latter drugs are longer in recovering, and even more likely to result in dementia than those not so treated. On the other hand, chloralamid is well borne even in attacks of acute mania; and with imbeciles and demented persons in whom no active cerebral disease is progressing, it also affords excellent results.

From these observations may we not justly conclude that chloralamid is a practical, safe and efficient hypnotic—exercising, when properly administered, a salutary effect upon central nervous tissue; relieving abnormal intercranial congestion, and strengthening peripheral nerve fibres, without depressing the action of any vital organ or interfering with the normal bodily functions.—*Notes on New Review.*

MEDICINE.

Insanity Following Surgical Operations.

In order to present this subject says Dr. Lears in the *Boston Med. and Surg. Jour.* in form for discussion I have formulated the following propositions:

1. That the insanity following operations is identical in form with that which follows acute disease.

2. That it may follow the most trivial operations as well as the most serious; that after gyencological operations it possibly is, and after cataract operations it probably is more common that after other surgical procedures.

3. That the aggregate number of cases is greater in women than in men, but that this disproportion would be lessened and might even disappear if only such operations as are common to the two sexes be compared.

4. That the causes are those which induce perverted or exhausted cerebral nutrition, among which are shock, fear or anxiety before operation, the sudden relief from strain after it, sepsis, malnutrition and advanced age.

5. That it is impossible to say that iodoform or other antiseptics may not have been the cause of some cases, in the same manner that drugs taken by the mouth may lead to mental disturbance, but that these cases are probably very few in number.

6. That it unsually appears within the first two weeks and may even come on immediately after the operation; that if it develops after the lapse of two or three months it is probably the result of other causes or is at best but indirectly connected with the operation.

7. That the prognosis is not particularly good, but 60 or 70 per cent. of the cases at most recovering; that recovery is more common in men than women, and when it occurs, takes place usually within a few months, but that the outlook is not absolutely unfavorable even if it continues for a longer period.

8. That hereditary influences are of comparatively slight importance while a condition of previous mental or nervous instability is a decided factor in inducing its appearance.

9. That when a patient shows a marked tendency to insanity, or when nental symptoms are already present, an operation is attended with much danger in this respect and great responsibility rests upon the surgeon who advises it.

10. That the progress of the wound is not influenced by the onset of insanity *per se*.

Tests of Death.

Dr. Edwin Howard describes a case in the *Lancet*, June 10th, in which the question whether death had occurred was entered into at length, because of the lifelike appearance of the body, and a history of a previous deathlike trance. With Sir Benjamin Ward Richardson the following ten tests were undertaken, two of which argued for, the other eight against, the presence of life. The paper is intended to show that the "diaphanous test" (No. 10) is unreliable, as in this case the fact of death was subsequently proved by waiting for decomposition. The list of tests is instructive, and may at any time be useful to a medical man.

(1) Heart sounds and motion entirely absent, together with all pulse movement. (2) Respiratory sounds and movements entirely absent. (3) Temperature of the body taken from the mouth the same as that of the surrounding air in the room, 62° F. (4) A bright needle plunged into the body of the biceps muscle (Cloquet's needle test) and left there shows on withdrawal no sign of oxidation. (5) Intermittent shocks of electricity at different tensions passed by needles into various muscles and groups of muscle give no indication whatever of irritability. (6) The fillet test applied to the veins of the arm (Richardson's test) causes no filling of veins on the distal side of the fillet. (7) The opening of a vein to ascertain whether the blood has undergone coagulation shows that the blood was still fluid. (8) The subcutaneous injection of ammonia (Monte Verdi's test) causes the dirty brown stain indicative of dissolution.

(9) On making careful movements of the joints of the extremities, of the lower jaw and of the occipito-frontalis rigor mortis is found in several parts.

Thus of these nine tests eight distinctly declared that death was absolute; the exception, the fluidity of the blood, being a phenomenon quite compatible with blood preter-naturally fluid and at a low temperature, even though death had occurred.

There now remained the diaphanous test (10), which was carried out by the aid of a powerful reflector lamp, the scarlet line of light between the fingers was as distinct as it was in living hands subjected to the same experiment.

Epileptic Neuralgia of the Face.

Dr. Fere reports a case in which neuralgia of the face is associated with epilepsy. This has been observed before; Trousseau declared it to be simply coincident. The absence of hereditary taint, of intellectual disturbances, and of simultaneous occurence of both affections, seemed to speak for the correctness of Trousseau's idea. In the following case, however, there is no absence of the foregoing symptoms, and what constitutes a further proof is that a cure of both diseases was brought about by the same remedy. The patient was a man 42 years of age, in whose family, on the maternal side, there was a decided hereditary taint. He had for six years been suffering from neuralgia of the face. At first the attacks occurred not oftener than every fourteeen days, and were confined to the left side. They began on the chin and at the same time the skin became red, followed by the development of confluent maculæ. In the course of years these attacks became more and more painful and frequently (as many as 20 in one day). At the same time spasms at the side of the eyelids accompanying the pains showed themsleves. Finally, after a number of medicines had been tried without benefit, epileptic attacks developed. By means of large doses of bromide of potash (7—10 grammes *per diem*) the epilepsy and neuralgia were cured within a few months, which would seem to show that the two affections had a common cause. —*Central Med.*

SURGERY.

Digital Compression in the Vomiting of Anæsthesia.

Dr. Bernard Joos describes a method for the control of the hiccough and vomiting during anæsthesia, which he has found successful for several years. It consists in digital compression of the phrenic and vagus nerve against the sternal end of the clavicle. His method is as follows: As soon as singultus or vomiting begins, the etherizer presses the last phalanx of the left thumb firmly over the sternal end of the clavicle, the body of the thumb being parallel with the clavicle and the hand resting on the chest. The pressure is made with the radial side of the thumb. The vomiting stops at once, as a rule. If needed, or more convenient, the pressure may be made on the right side. Pressure is continued for a few moments to prevent a return of the vomiting. He recommends the trial of this method in cases of sea-sickness.—*Bost. Med. and Surg. Jour.*

NEWS AND MISCELLANY.

Pan-American Medical Congress.

Committee of Arrangements, Washington, D. C.—Samuel S. Adams, M. D., Chairman; J. R. Wellington, M. D., Secretary; G. L. Magruder, M. D., Treasurer.

Executive Committee.—Dr. Samuel S. Adams, Chairmam; Surgeon-Generals Geo. M. Sternberg, U. S. A.; J. Rufus Tryon, U. S. N.; Walter Wyman, U. S. M. H. S.; Drs. S. C. Busey, G. Wythe Cook, Carl H. A. Kleinschmidt, H. L. E. Johnson, Llewellyn Eliot, H. H. Barker, C. W. Richardson, W. Sinclair Bowen, Geo. S. Ober, G. L. Magruder, J. R. Wellington, and John R. Walton, D. D. S.

SUB-COMMITTEES.

Reception.—Dr. S. C. Busey, Chairman; Surgeon-Generals Geo. M. Sternberg, U.S.A.; J. Rufus Tryon, U. S. N.; Walter Wyman, U. S. M. H. S.; Drs. J. Ford Thompson, Charles Hagner, Louis Mackall, J. Taber Johnson, T. Morris Murray, G. Byrd Harrison, and Jos. H. Bryan.

Entertainments.—Dr. G. Wythe Cook, Chairman; Drs. G. N. Acker and Thos. E. McArdle.

Registration.—Dr. Carl H. A. Kleinschmidt, Chairman; Drs. John S. McLain and Johnson Eliot.

Railroads.—Dr. H. L. E. Johnson, Chairman; Drs. E. L. Tompkins and J. Foster Scott.

Printing.—Dr. Llewellyn Eliot, Chairman; Drs. Thomas N. Vincent and F. B. Bishop.

Halls and Exhibits.—Dr. H. H. Barker, Chairman; Dr. J. T. Winter and C. M. Buchanan.

Ways and Means.—Dr. C. W. Richardson, Chairman; Drs. John Van Rensselaer, Wm. Dillenback, Henry B. Deale, and Wm. Compton.

Information.—Dr. W. Sinclair Bowen, Chairman; Drs. E. Oliver Belt and F. S. Nash.

Hotels.—Dr. Geo. S. Ober, Chairman; Drs. Wm. E. Handy and D. O. Leech.

Dr. Ernest Hart, Editor of the *British Medical Journal*, and Prof. Dr. Czerny, of Heidelberg, will be among the distinguished guests of the Pan-American Medical Congress. The latter is booked for the Pan-American Excursion to Rome by the "*Werra.*"

OFFICIAL DELEGATES TO THE PAN-AMERICAN MEDICAL CONGRESS.

Practically all of the Governments have appointed official delegates to the Congress

in response to the invitation by the President of the United States. The U. S. Government will be represented by six delegates. The larger cities of all the Latin-American Countries have appointed delegates to participate in the proceedings of the Sections of Hygiene, Climatology, and Demography, and on Marine Hygiene and Quarantine, and similar appointments will be made by the cities of the United States. Seventy-six similar delegates have so far been appointed by the Governors of States in the United States. A large number of delegates have been chosen by the medical colleges of the United States and other American Countries to attend the Section on Medical Pedagogics, under the Presidency of Professor J. Collins Warren, of Boston.

At the last meeting of the Ohio State Medical Society, the following officers were elected: President, N. P. Dandridge, M. D., Cincinnati; 1st Vice Pres., F. C. Larimore, M. D., Mt. Vernon; 2nd Vice Pres., Wm. Caldwell, M. D., Fremont; 3rd Vice Pres., W. T. Corlett, M. D., Cleveland; 4th Vice Pres., L. S. McCurdy, M. D., Dennison; Secretary, Thos. Hubbard, M. D., Toledo; Asst. Secy., Chas. Græfe, M. D., Sandusky; Treasurer, J. A. Duncan, M. D., Toledo.

ARMY AND NAVY.

U. S. ARMY FROM JULY 16, 1893, TO JULY 29, 1893.

Captain Leonard Wood, Assistant Surgeon is relieved from duty at Presido of San Franciso, Cal. and ordered to Fort McPherson, Georgia, for duty.

Captain Louis W. Crampton, Assistant Surgeon, is relieved from duty at Fort Spokane, Washington, and from temporary duty at Hdgrs, Dept of the Colorado, and ordered to Baltimore, Md. as Attending Surgeon and Examiner of Recruits, relieving Capt. Charles B. Ewing, Assistant Surgeon.

1st Lieut. James D. Glennan, Assistant Surgeon, ordered to report to the president of the examining board for examination for promotion.

Major Peter J. A. Cleary, Surgeon, granted leave of absence for four months on Surgeon's certificate of disability.

1st Lieut. A. E. Bradley, Assistant Surgeon, ordered to report to Lieut. Col. Sallas Bache, deputy surgeon general, president of examining board at Omaha, Neb., for examination for promotion to grade of Captain.

1st Lieut. J. T. Clarke, assistant surgeon, will on the abandonment of Camp Poplar River, Mont. proceed to Fort Sully, S. S. for temporary duty, and on return 1st Lieut. Bradley proceed to and take station at Fort Omaha, Nebraska.

Leave of absence for one month, to take effect between the 15th and 30th instant, is granted Major Calvin DeWitt, surgeon U. S. Army.

Captain Richard W. Johns, Assistant Surgeon, will report on or before August 6, 1893. to the commanding office Fort McHenry Maryland, for temporary duty at that post during the absence of Captain Charles B. Ewing, Assistant Surgeon.

Leave of absence for month, to take effect when his services can be spared at Fort Wingate, N. Mexico, is granted Major Louis M. Maus, Surgeon U. S. Army.

Leave of absence for two months, to take effect, on or about September 15, 1893, with permission to apply for an extension of one month, is granted 1st Lieutenant Benjamin L. Ten Eyck, Assistant Surgeon U. S. Army.

Captain William B. Davis, Assistant Surgeon, is releived from duty at Fort Sam Houston, Texas, and ordered to Fort Brown, Texas, for duty, relieving Captain George A. Torney, Assistant Surgeon.

Captain Torney upon being relieved, by Captain Davis, will proceed to and take station at Philadelphia, Pennsylvania, as Attending Surgeon and Examiner of Recruits at that place.
